A STUDY OF TRAUMATIC STRESS AND COPING STYLES AMONG KASHMIRI PEOPLE LIVING IN HIGH AND LOW RISK CONDITIONS

ABSTRACT

THESIS

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ABSTRACT

There has been a substantial and growing interest in the traumatic stress over the past century. Traumatic events are neither rare nor unusual across the life span. A range of situations such as military violent crime, technological disasters, earthquake, war may follow exposure to traumatic events or stress. More recently, terrorism-related trauma has become the most common and severe type of mental health problem that may follow exposure to a more intense traumatic stress e.g., threat to life, sexual assault and rape, detention in jail etc.

The present study was based on two simple premises: (a) identifying traumatic stress among Kashmiri people living in high and low risk conditions, and (b) coping styles used by the Kashmiri people living in high and low risk conditions to cope with traumatic stress.

Historical antecedents and conceptual issues related with trauma have been discussed in chapter one. Armed with this base of knowledge, psychological models, biological models, integrative models, ecological models and conservation of resources theory have been discussed in this chapter. A detailed account of the concept of *coping* and its style has been discussed.

The purpose of the present research was to develop two psychological tests meant for measuring traumatic stress and coping styles. The present research has set twelve objectives.

Review of relevant literature focussed on a number of traumatic events stemming from either war or violent crime (e.g., sexual abuse or rape), natural and technical (i.e., human caused disasters) being held captive (e.g., as a prisoner or war). A variety of military and civilian sources of trauma have been studied. This review noted a gradual but steady upward trend in the number of general or theoretical articles published on the subject. A recent review of research focussed on traumatic stress and coping behaviour appeared in the years between 1994 and 2000 have been cited in chapter two. Review of literature has been classified into four major sections: trauma and psychopathology, effects of trauma, therapy for traumatized individuals, and coping with trauma. Based upon earlier studies, it is clear that the present study on traumatic stress and its coping is rare as well as unusual. A thorough search of literature indicated that traumatic stress has not been linked to a wide variety of coping styles, including functional and dysfunctional.

This study was conducted on 100 Kashmiri individuals living in high risk conditions and 140 Kashmiri individuals living in low risk conditions. Two psychological tests, namely, traumatic stress inventory and coping styles inventory were developed following the quantitative method of item analysis. The split-half reliability for both the tests were also computed. The data were analyzed by means of item analysis and critical ratio of percentage.

Data analyzed by means of Critical Ratio have been presented in chapter Four. The main findings of the present study were:

Kashmiri individuals living in low risk conditions scored significantly higher percentages on *threat of firing, fear of crackdown or searching operations,* and *sexual assault and rape* traumatic stressors, whereas Kashmiri individuals living in high risk conditions scored significantly higher percentages on *anger, hostility and aggressive behaviour of administration, threat to life, unexpected death of a close family member during encounter* and *disintegration / breaking of the family* traumatic stressors than the comparison groups.

Males living in low risk conditions have scored significantly higher percentages than the females living in low risk conditions on the following traumatic stress: *anger, hostility and aggressive behaviour of administration, bomb blast near to my house, threat to life, survived by chance, torture of a family member in the prison, detention in jail of a close family member, dissociation from the family members,* and *detention in jail of oneself.*

Female subjects living in high risk conditions scored significantly higher than the female subjects living in low risk conditions on *anger, hostility and aggressive behaviour of administration, threat of life, unexpected death of a close family member during encounter, disintegration / breaking of the family,* and *detention in jail of oneself* traumatic stressors.

Kashmiri individuals living in high risk conditions have significantly adopted *I go for a walk or short trips,* and *I smoke*

cigarettes or tobacco coping styles, whereas the Kashmiri individuals living in low risk conditions used significantly higher on *I engage in watching T.V.,* and *I engage myself in some other activities like dancing or listening to music* as the coping styles to cope with traumatic stressors.

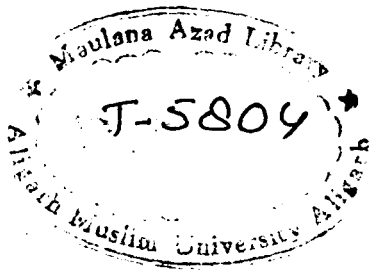
Males living in high risk conditions as compared to females living in high risk conditions used significantly more the following coping styles: *I go for a walk or short trips* and *I imitate the action of others who have had the same experience.*

Significant differences were found to exist between the males living in low risk conditions and females living in low risk conditions on the following coping styles: *I often think that help would come from God, I often think about the positive aspects of the situation I learn new skills to tackle the problem more effectively, I have been trying to cope with the situation through prayers and spiritual beliefs, I go for a walk or short trips, I prefer to live alone and engage in self-talking, I cut down my other responsibilities when the threatening situation arises, I cry, I blame myself and feel guilty about the situation that has happened, and I smoke cigarettes or tobacco.*

Significant differences were found to exist between males living in high risk conditions and males living in low risk conditions on *I learn new skills to tackle the problem more effectively* and *I engage in some creative activities like writing, reading, drawing etc.* coping styles.

Females living in high risk conditions scored significantly higher percentages than the females living in low risk conditions on *I smoke cigarettes or tobacco* and *I take tranquilizers* coping styles.

Chapter five presents conclusions and implications of the present research. The investigator by taking into account the methodology of the present study, and on the basis of data analysis and results, suggests possibilities for further research.



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Touseef Rizvi

(TOUSEEF RIZVI)

Chapter One

INTRODUCTON

The war for the establishment of the independent India was regarded as the final struggle and the ultimate victory for freedom. Indian history is centered around the effort to gain freedom from the political bondage. Despite many hurdles, freedom has won battles. Many died in those battles in the conviction that to die in the struggle against operation of British rules was better than to live without freedom. Such a death was the utmost assertion of their individuality. History seemed to be proving that it was possible for Mahatma Gandhi to govern himself, to make decisions for himself and to think and feel as he saw it. The full expression of Indian people's potentialities seemed to be the goal towards the establishment of the democratic society. Gandhiji's individualism in personal life give expression to the longing for freedom.

For more than one decade, India is facing threat to the democracy. This is due to the interference of other countries as well as the existence within our own personal attitudes and within our own institutions of conditions which have given authority, discipline and dependence upon the leaders in foreign countries. The battlefield in Jammu and Kashmir state exists not only in terms of socio-cultural context but also lies within ourselves. That is, the whole population is the will-less object of betrayal and terror.

TO ALMIGHTY

CONTENTS

ALIGARH MUSLIM UNIVERSITY
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Date : 16.02.2002

Supervisor's Certificate

This is to certify that the Ph.D. thesis entitled ***"A study of Traumatic Stress and Coping Styles among Kashmiri People Living in High and Low Risk Conditions"*** is an original piece of work and has been carried out under my supervision. The Ph.D. thesis is suitable for submission to the examiners for evaluation.

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If we want to fight terrorism prevailing in the state, we must understand it. Wishful thinking will not help us. And formulating formulae for negotiations or agreement will prove to be as inadequate and useless as the rituals of different regions of Jammu and Kashmir exhibited in their culture and traditions. In addition the problem of economic and socio-cultural conditions which have given rise to terrorism, there is the human behaviour of the people of Kashmir which needs to be understood. It is the purpose of this study to identify traumatic stress and coping styles in the people of Kashmir living in high and low risk conditions.

Traumatic stress and coping styles are the two psychological variables which are considered to be more important for the present investigation in the case of analysing and understanding the behaviour of the people of Kashmir. Besides the question of what kinds of traumatic stress occur among individuals living in high and low risk conditions, the most important question that needs to be answered is: what are the coping styles individuals adopt to cope with traumatic stress?

Traumatic stress

The first variable which we have studied here is the traumatic stress. There are certain traumatic stresses which are experienced by individuals in various conditions or situations. An individual experiences traumatic stress as a reaction to certain life conditions. Some of the traumatic stress like violent crimes, death of a close one and atrocities are not flexible in nature, for once they have become part

of an individual's behaviour, they do not easily disappear or change into some other forms. Generally speaking, traumatic stress are unfavourable to the growth and development.

Although traumatic stress is not a clearly defined area it has tended to include stressful events and circumstances that are both extreme and outside of the realm of everyday experiences. Stressors are best seen as a line on a continuam ranging from minor or everyday stressors to major stressors. Extreme stressors are those events and circumstances that because of their objective nature place massive demands on individual abilities to maintain psychological wellness, behavioural and cognitive functioning and physical integrity (American Psychiatric Association, 1987, 1994). Norris (1990) referred to traumatic stress as the population of the events involving "violent encounters with nature, technology or human kind".

Individuals are unlikely to be confronted with traumatic stress on any given day. However traumatic stressors occur more than one might think. Violent crime (sexual assault & physical assault), being held captive (arrest), killing of civilians are the frequent source of traumatic stress in Jammu and Kashmir. In addition to the direct victims of these events, emergency service workers such as people, fire fighters, and emergency medical teams are repeatedly exposed to accidents, killings, bomb blasts, grenade attacks, mine blasts, suicide squads. Individuals who are exposed to such type of traumatic events witness the horrible realities and live with the memories that accompany and follow these events.

Trauma has a far wider context and consequences on the individual and society. An individual's trauma involves a number of significant factors which can be considered as multidimensional and integrative in the context of social system. Among these are the physical, intrapsychic, the interpersonal, familial, social, communal, the educational-professional, occupational and the material, economic, political, national, and international. These systems coexist dynamically along the time dimension to create continuous conception of life from past through present to the future. Ideally the individual should simultaneously have free psychological access to the movement within all these dimensions.

In Kashmir, victimization leads to traumatic events and ruptures in the lives of people of Kashmir. Society has changed with the time, duration, extent, and meaning of the trauma for its victims and survivors; and the coping strategies they have used to adopt to it all depends upon the degree of victimization and rupture, the disorganization and severity of the choice of interventions. Tracing the history of multiple trauma along the time dimension at different stages of development reveals that in the case of traumatized people of Kashmir time does not heal but rather magnifies the response to further trauma. Thus, the present investigator feels that there is a need to examine the traumatic experiences, and coping styles in the people of Kashmir exposed to high and low risk conditions.

Victims of traumatic stress live in specific surroundings or situations in specifying societies, the characteristics of specific circumstances in Kashmir determine the intensity and severity of the consequences of extreme life events such as terrorism and violence. The occurrance of the traumatic events occur due to diverse situations such as political repression and military atrocities which create intense feelings of alienation, hopelessness and despair among people of Kashmir.

Trauma : Historical Antecedents and Conceptual Issues

Since the introduction of the concept of posttraumatic disorder in 1980 by the third edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-III, American Psychiatric Association, 1980), trauma has become a very popular concept for studying in various disciplines such as psychology, psychiatry and the social sciences. In recent years it is gaining popularity and is growing rapidly. The inclusion of this diagnostic concept in psychiatric and psychological nomenclature has played a central role in focussing society's concern on the impact of trauma. Previously, there was a tendency to underestimate the role of trauma and to use individual vulnerability as the reason for people's suffering. This meant that the victims suffering was dismissed and stigmatized. However, careful examination of the literature suggests the traumatic events do not have a uniquely powerful relationship to the onset of subsequent symptomatology.

At the end of the 19th century, Hermann Oppenheim introduced the concept of traumatic neurosis. Pierre Janet, Joseph Breur, and Sigmund Freud examined the traumatic nature of the disturbance of hysteria. The term trauma became established in the scientific vocabulary, but gradually, the interest in phenomena related to the impact of violence, abuse and other extreme events moved to the background. Nevertheless, it appeared again in the literature, after world war I and II and after other dramatic catastrophes and calamities. The current concern developed as a result of the aftermath of the interference of the United States in Vietnam, the increasing attention to victims of urban violence and the need to help abused women and children. This interest has acquired a central place in the scientific study of trauma and researches have focused on events, situations and circumstances aspects.

There are a number of problems or serious life conditions that seem to be associated with trauma. They are: 'individual with powerlessness', 'disruption', and 'death as in acts of violence', 'natural disasters', 'combat', 'human rights violations', and 'the sudden loss of loved ones'. the origin of the individual problems is formed in an external factor, something problems is formed in an external factor, something outside the person. Currently, clinicians and researchers have shifted form the traditional approach i.e. studies based on personality and other interpersonal factors, to something outside the person.

There has been a substantial and growing interest in the topic of traumatic stress over the past century. A variety of military and civilian sources of trauma have been studied. The impact of war conditions upon civilians-concentration camp survivors, relatives of combatants, civilians living in war torn regions was studied (Hobfoll and London, 1986; Hobfoll, Lomranz, Eyal, Bridges, Tzemach, 1989; Lomranz, Hobfoll, Johnson, Eyal & Tzemach, 1994; Solomon, 1988). Violent crime (e.g., sexual assault, physical assault) has also become a major area of inquiry (Kilpatrick, Best, Veronen, Amick, Villeponteaux, Ruff, 1985, Kilpatrick & Resnick, 1993). A recent review of the research focused on traumatic events such as natural disasters (Freedy, Kilpatrick, & Resnick, 1993; Gibbs, 1989; Rubonis & Bickman 1991), disasters caused by technological failures (Baum, 1987; Butcher, & Hatcher, 1988; Jacobs, Quevillon, & Strichetz, 1990; Green, Lindy, Grace, Gleser, Leonard, Karol, & Winget, 1990; Williams, Solomon, Bartone, 1988), accidental injury (Kuch, Swinson, & Kirby, 1985; Scotti, Beach, Northrop, Rode, & Forisyth, 1995), refugee status (Burkle, 1983; Eisenbruch, 1991; Kinzie, 1989; Kinzie, Sach, Angell, Clark, & Ben, 1989), and torture (Vesti & Kastrup, 1992). This review noted a gradual, but steady, upward trend in the number of articles published on the subject. Their findings indicate that theoretical and empirical work regarding traumatic stress stemming from either war or violent crime (e.g. sexual abuse or rape) were most common.

Conceptual Models

Researchers in the field of traumatic stress offered a number of models.

Psychological Models

Two psychological explanations for the development of mental health problems following traumatic events have been forwarded. The first explanation is based upon learning theory principles. The second explanation focusses on the relevance of cognition and perception in the development of mental health difficulties.

A learning theory explanation for the development of anxiety has been proposed with regard to combat trauma (Keane, Zimering, & Caddell, 1985) and crime related trauma (Kilpatrick, Veronen, & Resick, 1979). The explanations are based upon principles of Mowrer's (1960) two-factor theory. From this point of view fear is considered classically conditioned (first-factor). The second factor concerns instrumental avoidance behaviour. Trauma victims may avoid certain cues in order to minimize experiencing overwhelming memories.

Learning theory model provides an adequate explanation for the etiology of a subset of PTSD symptoms. There are a number of symptoms, namely, the development of certain arousal symptoms (e.g., exaggerated startle response) and avoidance symptoms (e.g., avoidance of thoughts and feelings related to the trauma) which are addressed within the learning theory framework (APA, 1994). However,

the development and maintenance of re-experiencing symptoms are not addressed by a learning theory approach. In particular the problem of re-experiencing symptoms of PTSD (e.g., recurrent and distressing memories of the trauma. recurrent distressing dreams) is not addressed by learning theory. The development and maintenance of intrusive cognitive symptoms require a theoretical explanation that extends beyond principles of classical and operant conditioning (Foa & Kozak, 1986; Foa, Steketee, & Olasov-Rothbaum, 1989).

An early cognitive processing model has been suggested by Horowitz (1986). He proposed that memory processes contain a motivational component. He noted that humans seek to understand the meaning of various life experiences. Thus, images of an event are held in "active memory" as the individual seeks to determine the personal relevance of an experience. In the case of life threatening trauma, the individual's basic biological and emotional existence are threatened. This state of affairs presents huge challenges to typical patterns of thinking (i.e. Psychological defences about the self and the world). From this perspective, repetitive recollections of traumatic memories alternating with avoidance behaviour and feelings of numbness represent an effort to integrate traumatic memories into an acceptable view of the self (e.g., worthwhile, competent) and the world (e.g., Controllable, predictable).

A number of cognitive processing models have been proposed to explain the phenomenon of mental health problems. Foa and others

(1989) proposed a "fear-based memory network develops following trauma and contains information regarding trauma-related stimuli, responses to the trauma (thoughts, feelings, behaviour), and the meaning of trauma stimuli and subsequent responses. PTSD is proposed as developing when previously safe situations or people are associated with extreme danger during the trauma. Reexperiencing phenomenon (e.g., memories, nightmares) reflect the inability to activate the fear network long enough to modify elements of the memory. Activation of the memory network and incorporation of accurate information regarding trauma (e.g., no one deserves to the raped) are made difficult by the naturally occurring avoidance of thinking about or discussing the trauma. For modification of the fear structure to occur, the memory must be activated and new information incompatible with the perception of pervasive and chronic danger must be integrated. Cognitive-behavioural psychotherapy may be required to help the trauma victim accomplish this goal.

An additional information-processing approach was proposed by Resick and is derived from the work of McCann and her colleagues (McCann & Pearlman, 1990; McCann, Sakheim, & Abrahamson, 1988; Resick & Schnicke, 1993). This approach suggest that traumatic experiences confront the victim with information that is highly discrepant from typical beliefs (cognitive schema) about the self and the world. Typical schema include issues such as safety, trust, power, esteem intimacy, hope, causality, and control. This viewpoint suggests that suffering in the aftermath of traumatic events largely involves

wresting with the meaning of the event in terms of issues defined by existing beliefs. The meaning attributed to the trauma and one's role in the trauma will largely determine the course of adjustment (positive or negative) in the aftermath of the traumatic event. This approach broadens other information-processing viewpoints by identifying a range of schemata (i.e., beyond beliefs concerning safety) that can be challenged by traumatic experiences.

Biological Models

Biological aspects of human responses to trauma have been examined by various researchers in the field (Blanchard, Kolb, Gerardi, Ryan, & Pallmeyer, 1986; Blanchard, Kolb, Pallmeyer, & Gerardi, 1982; Pallmeyer, Blanchard, & Kolb, 1986; Pitman, Orr, Forgue, Altman, de Jong; & Hertz, 1990). These researchers acknowledge that biological factors are one of the several important factors influencing the nature and course of post-trauma adjustment.

Studies of animals provide a model for understanding biological factors underlying post-trauma adaptations in humans e.g., it has been suggested that the inability to escape shock may lead to identifiable biological changes. Animals exposed to inescapable shock demonstrate a transient depletion of certain neurotransmitters (e.g., norepinephrine, epinephrine, and dopamine). The depletion of these neurotransmitters has been shown to produce symptoms that appear to parallel the negative symptoms of PTSD in humans : these symptoms include the constriction of affect, social withdrawl, and a decrease in

goal-oriented behaviour (van der Kolk, Greenberg, Boyd, & Krystal, 1985).

On the basis of the results of animal studies of inescapable shock, Kolb (1988) has proposed a conditioned emotional response (CER) model. This model suggests that prolonged exposure to a painful, inescapable threat may produce an alteration in the neurological structures within the brain, particularly within the limbic system. According to the CER model, traumatic events may lead to an excessive stimulation of particular areas within the limbic system, particularly the locus coeruleus. The neurons of the locus coeruleus are activated by external threatening stimuli; and when stimulated, the organism displays behaviours typifying fear and alarm. The pairing of non-threatening with threatening stimuli may lead to an over-activation of the locus coeruleus producing fear behaviour in response to otherwise neutral stimuli. Over-time, this prolonged stimulation leads to a generalised hyperactivity of the locus coeruleus and the resulting conditioned alarm state that characterizes PTSD.

To date, research on human subjects has primarily focussed on the role of the autonomic nervous system in post-trauma adjustment. Several studies have demonstrated that combat veterans with PTSD have significantly higher resting heart rates and systolic blood pressures than do comparison groups (Blanchard et al., 1982; 1986). In addition combat veterans with PTSD show reliable patterns of physiological reactivity when exposed to combat-relevant cues (visual and auditory combat-

related stimuli such as slides of battle scenes or audio-tapes of combat) in comparison to non PTSD veterans, generalised anxiety disorder patients, and normal subjects (Pallmeyer et al., 1986; Pitman et al., 1990). These findings suggest that the autonomic nervous system plays a key role in post-trauma adaptation. However, it is not clear whether autonomic elevations and reactivity precede the development of PTSD. It is possible that autonomic elevations and reactivity represent a consequence of trauma exposure.

Barlow (1988), Jones and Barlow (1990), have proposed that post-trauma adaptation may be related to an inherited biological predisposition to experience anxiety. This model suggests that people may inherit an autonomic nervous system with two characteristics : (1) a high resting rate (e.g. heart rate, blood pressure and (2) a high rate of reactivity to threatening stimuli. It is proposed that this biological vulnerability in combination with an intense and/or prolonged stressor may result in debilitating levels of anxiety. This model suggests that stressor may be either environment (e.g., a serious car accident) or internal (e.g. thoughts about environmental threats or internal sensations). This model also suggests that certain individual factors (e.g., social support, coping responses) may raise or lower the probability of a stressor combining with the inherited biological vulnerablity to produce debilitating anxiety. At present, this biological vulnerability model is speculative as it lacks firm empirical validation.

Integrative Models

The models relating to the etiology of PTSD tended to focus on the role of single factors (e.g., conditioned anxiety, cognitive processes, biological vulnerability) in determining adjustment. The merit of such approaches lies in their potential for clear explanatory power. In essence, integrative models attempt to integrate the potential importance of a variety of psychological, social, and biological factors in the etiology and maintenance of PTSD.

Foy and his colleagues (1993) proposed an integrative model concerning to the PTSD etiology and maintenance. It has been proposed that trauma exposure may lead to conditioned emotional reactions that become either acute or chronic PTSD. The model proposes three routes by which the conditioning of post-trauma anxiety may occur: (1) direct personal experience (e.g., being rapid), (2) observation (e.g., witnessing death or severe injury); or (3) vicarious experience (e.g., learning of harm to other person).

The Foy model also proposes that other factors may mediate between trauma exposure and the conditioning of acute or chronic PTSD symptoms (Foy, Osato, Houskamp, & Neumann, 1993). These psychological, social and biological factors are referred to as risk factors when their presence increases the probability of PTSD developing. Alternatively, these factors are termed resilience factors when their presence decreases the probability of PTSD emerging. The model suggests that it is an empirical matter to determine the existence

of risk or resilience factors in PTSD development and maintenance of PTSD. The emphasis upon the empirical validation of proposed etiology mechanisms is an appealing feature of the Foy model. In addition, the explicit recognition of the potential importance of psychological, social and biological factors in the etiology and maintenance of PTSD is useful. The future advancement in conceptual understanding of the PTSD will rely on models that attempt to integrate psychological, social and biological mechanisms.

Ecological Model

The Conservation of Resources (COR) theory provides an ecological model that may have the advantage of being grounded in the more general stress theory, while at the same time showing promise in understanding the critical function of resource loss in traumatic stress. By focussing on the full array of people's resources, attention is extended beyond an individuals psychology. Instead, COR theory's resource emphasis highlights the need to understand the individual in an ecological context, owning many personal resources, sharing some social resources, and having possible access to the resources of the larger system.

The model highlights that resources may be lost on various ecological levels, ranging from the individual and family to the organization and community. A number of predictions follow from the model.

Prediction 1 : The close the loss is to the individual and family level, the more powerful the impact of loss will be. Hobfoll, London, and Orr (1988) found that surviving soldiers' combat losses were still psychologically and functionally debilitating to them when after their female loved ones had recovered from the threat of loss that the women experienced while their male loved ones were at war. For the soldier, then the loss was final.

Prediction 2 : Loss at the higher level of ecology inhibits successful coping at the lower levels, for example, Zafrir (1982) described the use of community level resources to aid families and individuals striken in a terrorist attack. This attack involved two buses being attacked, with the result that 16 passengers were killed and 24 wounded. The authorities coordinated efforts to provide a full range of assistance to the victims and their families (eg., providing information quickly and sensitively, providing assistance with the grief process).

Prediction 3: "Boarder resources are defined as resources that join the different levels" for example, the individuals willingness to seek help is a resource that we can depict as laying on the border between individual or family resources and organizational or community resources Resources that interface or connect different levels of resources are necessary to support optional functioning. Another border resource is having a large social network that consists of both family and colleagues, hence being a resource between family resources and organizational resources. Hence, prediction 3 is that loss of support at

one level (e.g., organisational level) may be compensated for in part, by support resources at the other level (e.g., family level). Loss at both levels of support would have the most severe impact on well-being.

Prediction 4 : Prediction 3 leads to prediction 4. Specifically as more border resources are lost, the ability of the lower level entity benefit from the higher level entity is lost. This occurs because the 'connective tissue' between the various levels is necessary for cross border resource utilization rather than being interconnected, marked border loss results in a dissociation of the individual from the family, the family from the organization, or the organization from the community. This isolation of available resources increase vulnerability to ongoing levels of loss and associated psychological distress. The aforementioned situation may result following exposure to particularly chronic forms of traumatic stress (e.g., domestic violence, community violence, violence within the schools).

The ecological model based on conservation of resources theory adds the insight that enabling resources (sense of mastery and social support) can be targetted. The ecological adaptation of COR theory further suggests that border resources will be critical. The framework further illustrates how COR theory also differs from other stress theories in its emphasis on objective stressors and its relative minimization of the importance of perceptions. This is not to say that perceptions are not one component of the trauma experience but that their place has been over emphasized relative to objective events and

the objective resources of individuals. It is not that one perceives trauma to be threatening; rather it is threatening. Likewise, imagined resources (e.g., a false sense of self-esteem perceived but with little real depth or strength) will be quickly vanquished in the face of traumatic stress experiences. Traumatic stress research and practice have tended to be descriptive, observational and reactive; COR theory might provide one framework for promoting a more apriori approach to the conceptualization of the traumatic experience, providing a guide for clinicians, service delivery managers, researchers and policy makers.

Conservation of Resources (COR) Theory

The COR theory has been developed as a general stress theory that helps to explain why certain circumstances are stressful and the process of people's reactions to stressful circumstances (Hobfoll, 1988, 1989; Hobfoll & Lily, 1993). As a general theory of stress, it can help us understand both the similarities and differences inherent in traumatic stress as compared to major stressors, everyday stressors and minor hassles. The COR theory is based on the premise that individuals strive to obtain, retain, and protect their resources. Resources are defined as those things that are highly valued by individuals or that serve as a means of obtaining those things that are highly valued. Hobfoll, Dunahoo and Monnier (1994) have suggested four major kinds of resources. They are : (1) Object resources (e.g., Car, home, clothing), (2) Conditioned resources (e.g., tenure or

seniority at work, a good marriage), (3) Personal resources (e.g., occupational skills, sense of self-esteem), (4) and energy resources (e.g., money, credit, insurance).

They argue that stress occurs under any of these conditions :

First, when there is the threat of significant resource loss.

Second, when there is actual resource loss.

Third, when resources are invested without resulting in significant resource gain, hence producing a net loss of resources since more resources were lost in the process of investment than were gained as an outcome of investment.

There are some key resources such as health, children, the family, work, leave, honour, and sense of control which are universally valued (Schwartz & Bilsky, 1990), even if their rank order or interpretation are more culturally specific. Most of the stress researchers focusses on to compare people within a given culture, not between cultures, there is a reason to believe that a common set of resources is valued when victims of traumatic stress are viewed within one culture.

The COR theory predicts that since people strive to protect their resources, attempts at gain will actually increase amidst loss. The experience of being assaulted may cause a person to begin an escort service outside the home or to demand to the authorities for patrolling in the locality and better lighting in the area. These efforts may

increase sense of efficacy. Similarly, ruin of one's home in a fire or bomb blast may result in increased family closeness, on the one hand, and family conflict, on the other hand, as the family must live in a motel while repairs or reconstruction is completed. Ozer and Bandura (1990), found that participating in a highly aggressive self defense, course increase previously raped women's sense of self-efficacy. We would underscore not only the increase in the self-efficacy, but also the very fact that women sought such groups perhaps a form of bolstering social resources) following their traumatic experiences.

Principles and Corrolaries of COR Theory

The COR theory outlines a number of key principles. These principles will help us to understand how traumatic stress affects people.

Principle 1 : The Primacy of Loss

A potential criticism of COR theory lies in the principle that "loss is more heavily weighted by individuals than is gain. The preeminence of loss over gain in cognitive psychology is well established (Tversky & Kahneman, 1981). It has been found that in the process of decision making, outcomes framed in terms of loss are weighted more strongly than outcomes framed in terms of gain. In medical research Tymstra (1989) similarly finds that people will invest significant resources to limit the possibility of future loss, even if they must undergo difficult and painful medical procedures. Hobfoll, Lilly, and Jackson (1992), have found that resource loss is highly correlated with psychological distress.

According to Hobfoll and Lily (1993) resource gain has limited effect on psychological distress. Even when people make gains clinicians should be cautious not to overestimate gain's positive impact. The effect that resource gain does have occurs in the context of offsetting loss. e.g., when a person is ill, improvements in health (gains) become significant but hearing that he is well when he has not been ill has little or no effect on well being.

Loss is the essence of stress. COR theory argues that change per se is not stressful. In earlier studies it was found that change itself was stressful, both positive and negative changes were mixed by presentation of ambiguous events e.g., stress was found in early research to follow changes at work changes in marital life and financial change (Holmes & Raye 1967). However, subsequent research found that these negative consequences of change only occurred when change entailed loss or threat of loss (Thoits, 1983). Thus, when change was rephrased to ask, "was the change positive or negative?" Only those who indicated of negative change showed adverse reactions. In fact, positive changes actually buffer against negative changes (Cohen & Hoberman, 1983). Thus, positive changes makes one more resistant to negative stress reactions. This does not mean that times of change are not times to be watchful. Many changes that on their surface are positive can have negative aspects. For example, finding a job in another place may mean higher pay and prestige, but loss of friends. Although COR theory sees both losses and gains as important, it would emphasize the impact of the loss events. Given that losses overweigh gains, it should also be

underscored that a few significant losses may produce more extreme effects than either individuals or mental health professionals might anticipate.

Early research on stress depicted stressors as individual events, in the sense of being static occurrences. e.g., exposure to an earthquake, fire, or flood was depicted as uniform. Dohrenwend, Raphael, Schwartz, Stueve, and Skodol (1993) presented a method for unpacking events into their many components. Hence, a disaster consists of possible financial loss, increased child care burden, loss of home, and loss of mutual friends. The same disaster might result in gains in other resources, such as increased self-esteem and independence if one were to master disaster-related challenges. Such unpacking of event component is critical if we are to decompose the loss and gains that together comprise the changes that occurred.

Principle 2: Resource Investment

Another principle of COR theory is that individuals must invest resources in order to obtain, retain, and protect resources. The authors (Hobfoll, Dunahoo, & Monnier, 1995) have explained this principle with the help of few examples. For instance, to protect against loss of selfe-steem, people must invest their self-esteem. If one is threatened with a failure experience, it is often possible to offset the loss of self-esteem by convincing oneself that one has greater worth than this and that this single failure is not so significant in light of many past accomplishments. Alternatively, people often invest one resources

to protect a second resource. For instance, social support may be used to offset the loss of sense of self-esteem, as others convey to us messages of our worth amidst some difficult circumstances that threatens self-evaluation.

How are resources invested ? Schönpflug (1985) has illustrated that coping demands the use of resources. Energy resources, e.g., are often needed, as when survivors invest time in rebuilding their homes. It is obvious how money is invested to produce other resources as more money, sense of success, or even self-esteem. Other, less concrete, resources must also be invested to be of value, e.g., we must call no friends following exposure to a serious stressor (e.g., serious accident) if we are to receive support from them. Extreme stressful events (e.g., physical assault, or chronic major stressors (e.g., community violence) must be confronted with our inner resources. Similarly, in our attempts to develop intangible resources such as love, we must invest time, energy, trust, and self-esteem. Even after this investment, we risk the loss of all occur investment if our attempts are rejected. Hobfoll and others (Hobfoll & Learman, 1988; Hobfoll, Nadler & Leiberman, 1986) have repeatedly found that those who are able to invest their resources more successful resist the more negative impact of stressful circumstances than those who either lack or misuse resources. Clinicians can often aid people prior to or after trauma by helping them (1) identify their resources and (2) invest them appropriately.

Loss is closely associated with traumatic stress than in any other types of stress. It is the nature of traumatic stress that loss is rapid, extensive (i.e. many resources lost), and deep (i.e. many losses are major in proportion). This often means that the sense of how much is lost is overwhelming to the individual. The losses typically cross all resource domains; object resources, condition resources, personal resources and energy resources are all affected. Further, since resources are needed to offset further secondary loss, the depleted resource reservoir is found emptied of the necessary tools for successful stress management (Hobfoll, 1991). Again, because resources have been cut rapidly, broadly, and deeply, the usual arsenal of coping responses in damaged in way that leaves people much less capable of responding to stress.

Freedy, Shaw, Jarrell and Masters (1992) inquired the victims of Hurricane Hugo about their resource loss, coping behaviour and personal characteristics (gender, marital status and household income). Levels of subsequent psychological distress were also assessed. Personal characteristics explained 9.5 percent of the variance in psychological distress, and the aggregate of all coping behaviour explained 7.9 percent of the variance in psychological distress. Resource loss, in contrast, explained 34.1 percent of the variance in psychological distress. Women and men with high loss had four to eight times the likelihood of experiencing clinically significant psychological distress than men and women who experienced low levels of resource

loss, respectively. These findings strongly support the central role of resource loss in disaster responding.

Freedy et al. (1992) also examined the COR based hypothesis that loss would motivate more coping behaviours. This prediction contrasts with the assumption that negative events paralyse victims or that victims become helpless. They found that both favourable (e.g., problem-focussed coping) and unfavourable coping (e.g., disengagement) were positively related to greater loss. This finding provides insight into the process of responding to stress by suggesting that victims become active in initiating whatever patterns of coping behaviours are contained within their repertoire. Some of this responding produces beneficial outcomes and some creates further difficulties, but underlying both mechanisms is the attempt to cope. When we examine their data more closely, it is of further interest that although women reported more losses than men, men with high levels of resource loss were more likely to report clinically significant levels of psychological distress. This suggest that examining resources loss may circumvent problems with males' traditional underreporting of psychologically relevant symptoms as their reports of loss reveal a fuller picture of the extent of potential impact following a traumatic event.

Principle 3: Loss and Gain Spirals

This principle follows from preceding assumptions and principles. If (1) stress follows loss, threat of loss or failure to gain;

(2) loss in more heavily weighted than gain; and (3) people must rely on resources to offset resource loss, then it follows that initial loss will make individuals more vulnerable to further loss. Loss spirals can begin very quickly. They also may have a long term course affecting individuals for years after the original event.

Resource loss and Resource gain Spirals

After confronting initial resource loss, people have fewer or less potent resources for the additional challenges that come in the wake of the first loss circumstance. Self-esteem or sense of mastery may be lower, favours may have been used up, and such resources as money, and insurance may have been fully or partially depleted. Now, with the exposure to secondary stressors, further loss occurs, each loss resulting in an increasing level of vulnerability as resources are further depleted.

Gain spirals follow a similar process. Initial gain creates a system more resistant to stress and more capable of further gain. However, since loss is weighted greater than gain, there are two attributes of loss cycles that differentiates them from gain cycles. Specifically, loss cycles are more potent than gain cycles and occur at greater acceleration. This difference becomes critical when considering traumatic stress, as the initial stressor is, by definition, one that threatens or creates major resources loss. Following initial loss, many traumatic stressors may contribute to a sequence of further losses, each attacking the individual, group, or community which has ever-decreasing resources.

A number of intervention principles are highlighted here that follow a theoretical understanding of the mechanism of loss and gain spirals. If loss spirals occur with a steeply increasing slope of speed and ever greater impact, then it follows that is critical to intervene early, before momentum is gained. Intervention should be mobilized in a matter of hours after impact of the extreme stress. The later intervention occurs, the harder it is to offset the spiral's damaging impact. Early intervention can often offset loss cycles and either stabilize stress reactions or even set the stage for a gain cycle (Hobfoll & Jackson, 1991). Gain cycles, on the other hand, occur more slowly. For many important areas of gain meaningful milestones are only accomplished in terms of months and years. A fire can destroy a home or business in moments. To build a business or save enough to purchase a home may in contrast require years of investment. More intangible resources operate similarly. e.g., trust can be destroyed by a single failure of supporters to come to survivor's aid following victimization whereas building a trusting relationship can require years. These insights help underscore the consequences of exposure to traumatic stressors, as they influence loss cycles and interfere with long term gain cycles.

Coping with Traumatic Stress

The study of stress and coping has become quite popular in recent years, particularly in regard to traumatic life events. Although the area is broad and the coping process is complex, there is a striking coherence in much of the literature. This coherence is based on two

concepts central to an understanding of coping with trauma; approach and avoidance. In essence, this pair of concepts refers to two basic orientations towards stressful information, or two basic models of coping with stress; approach and avoidance are short hand terms for the cognitive and emotional activity that is oriented either toward or away from threat.

Coping has played a central role in adaptation but yet there is no universal agreement on the definition of coping. Because coping has always been linked to the concept of stress, its recent popularization has been occasioned by a marked growth of interest in the stress concept. The links between stress and coping is an inevitable feature of the human condition. In everyday language an individual's ability to cope refers to their successfully accomplishing a task of dealing with a situation. Health psychologist have followed the everyday use of the term coping.

Coping: Nature and Definitions

The concept of coping has been studied in various disciplines Sociologists, e.g. refer to the ways in which a social order adjusts to a crisis, and biologists speak of the adjustment of a tissue system of the body the noxious events as in Seley's (1956, 1976) "General Adaptation Syndrome". However, coping is primarily a psychological concept. In psychological usage, there are many definitions of coping, but all share a central theme, namely, the struggle with external and internal demands, conflicts, and distressing emotions.

Coping refers to a person's active efforts to resolve stress and to create new ways of handling new situations at each life stage (Erikson, 1959). This idea emphasizes the importance of the personal resource and competencies that are use to deal with new challenges. Coping emphasizes mastery of the situation while defense emphasizes protection of the self. This is not to imply that coping occurs with no regard for the self. The coping process requires an effective person who actively engages each life challenge.

White (1974) identified three components of coping. First, coping requires that the person be able to gain and process new information. New information is needed to understand a difficult situation more fully or to establish a new position in the face of threat. Second, coping requires that the person be able to maintain control over his or her emotional state. This does not mean doing away with emotional responses. Rather, it suggests the importance of correctly interpreting emotions, expressing them when necessary, and limiting their expression when necessary. Third, coping requires that the person be able to move freely in his or her environment.

The goals of coping include the desire to maintain a sense of personal integrity, and to achieve greater personal control over the environment. In each situation, the person uses physical, cognitive, social, and emotional resources to understand what is needed. Then they modify some aspects of the situation or the self in order to achieve a more adequate person-environment fit. Coping then is behaviour that

occurs after the person has had a chance to analyze the situation, take a reading of his or her own emotions, and to move to a closer or more distant position from the challenge.

The term coping has two meanings in literature. The term has been used to denote the way of dealing with stress, or the effort to master conditions of harm, threat or challenge when a routine or automatic response is not readily available (Lazarus, 1974). Coping refers to efforts to master conditions that tax or exceed adaptive resources (Monet & Lazarus, 1977). At a general level, coping has been broadly defined as "any effort at stress management" (Folkman & Lazarus, 1980). The term coping is viewed as a stabilizing factor that may help individuals maintain psychological adaptation during stressful period (Folkman & Lazarus, 1985).

Definitions given by Menninger (1963), Haan (1977), and Vaillant (1977) imply a hierarchy of adaptationally focussed efforts with "coping" representing mature ago processes and "defenses" representing immature and less serviceable variations of the same essential cognitive processes.

Pinkerton et al. (1985) have defined coping as the minimization of emotional distress. This places coping as the dependent variable and looses the notion of different coping cognitions/behaviours being enacted in an attempt to limit the effects of stress.

The most commonly used definition of coping is put forward by Folkman and Lazarus. They see coping as a psychological mechanism

for managing psychological stress (Lazarus & Folkman, 1984). This mechanism may be both action oriented and intrapsychic and is intended to avoid or mitigate the consequences of stressor (Cohen, 1987).

Lazarus and Folkman (1984) recognised the value-laden nature of certain traditional ways in which coping has been defined. They define coping at the psychological level of analysis as "the process of managing demands (external or internal) that are appraised as taxing or exceeding the resources of the person". This definition has several important functions. First, it emphasizes "process" as distinguished from trait or style. Second, it speaks of management rather than mastery; since many human problems (e.g., terminal illness, ageing) cannot be mastered, they must be redefined, tolerated, endured, or accepted for optimal adaptation. Third, the term "appraisal" indicates the central role of psychological mediation. Finally, they view coping as establishing the mobilization of effort.

Investigators have employed two different approaches to study of coping. On the one hand, some researchers (e.g., Byrne, 1964; Goldstein, 1973) have emphasized general coping traits, styles or dispositions, while, on the other, some investigators (e.g., Cohen & Lazaras, 1973; Katz et al., 1970; Wolf & Goodell, 1968) have preferred to study the active ongoing strategies in a particular stress situation.

Dewe and others (1979) defined coping as an individual's attempted response to reduce feeling of discomfort. To Burke and Wier (1980) coping process refers to "any attempt to deal with stressful

situations when a person feels he must do something about, but which tax or exceed his existing adaptation response patterns". Maddi and Kobasa (1984) have discussed two forms of coping: (1) Transformational coping involves altering the events so they are less stressful. To do this, one has to interact with the events and by thinking about them optimistically and acting toward them decisively, change them in a less stressful direction. (2) Regressive approach to coping includes a strategy wherein one thinks about the events pessimistically and act evasively to avoid contact with them.

Houston (1986) proposed the more extensive classification system that can be applied to stimulus, process, or other response based definitions of stress. He defined coping as a response or responses whose purpose is to reduce or avoid psychological stress (negative feelings). It is pointed out such responses may or may not be successful in reducing psychological stress.

Definitions and conceptualization of coping have spanned a wide range of views including: (a) coping as a personality trait or disposition versus coping as a situational-based or state-like effort; coping strategies as inherently adaptive, reality-based, conscious, and purposive approaches versus coping or defense strategies as global, primarily intrapsychic reality-distorting, rigid and maladaptive processes; and (c) the nature of coping classification (e.g. approach versus avoidance coping, instrumental / active versus affective / passive coping; adaptive versus maladaptive coping (Billings and Moos, 1984;

Haan, 1977; Holahan, Moos & Schaefer, 1996; Lazarus & Folkman, 1984).

Types of Coping

Several different formulations of the coping behaviour is followed by the researches in the field. There is no individual technique and widely accepted models for categorizing differences in coping styles. There are studies which observe responses to specific kinds of stress. Coping strategies include feeling incapable of being hurt: denial of stress; worrying when you know stress is coming and resilience in recovering from stress. The distinction between "problem focussed" and "emotion-focussed" coping has been made by Mechanic (1974), Kahn et al., (1964) and White (1974). *Problem-focussed* coping refers to efforts directed at doing something constructive about the conditions that harm, threaten or challenge. *Emotion-focussed* coping refers to efforts directed at regulating the emotion itself, whether the focus of such regulation is in behaviour and expression.

Lazarus (1975), suggested two categories of coping, viz., "direct action" and "palliative modes". *Direct action* deals the behaviour of actions which are performed by the organism when it is in the face of stressful situation. *Palliative approach* of coping refers to those thoughts or actions which purport to relieve the organism of any emotional impact of stress.

According to Lazarus and Launier (1978), coping is the "effort, both *action oriented* and *intrapsychic* to manage (i.e. to master,

tolerate, reduce and minimize environmental and internal demands and conflicts among them) which exceed a person's resources". McGrath (1976) believed that an array of covert and overt behaviour patterns, which can help prevent, alleviates or respond to stressful experiences is known as coping. In the more recent literature on coping with stress, approach-avoidance distinction is a core idea. One is struck by the extent to which the concepts of approach and avoidance underlie the personality or individual difference variables studied in the anticipatory threat literature, and also the dimensions of coping studied in traumatic stress reaction research (Roth & Cohen, 1986).

Wilder and Plutchick (1982) have proposed eight basic coping styles to reduce stress: suppression (avoid and stressor), help seeking, replacement (engage in direct stress reducing activities), blame (other and system), substitution (engage in indirect stress-reducing activities), mapping (Collect more information), reversal (act opposite to the way one feels), minimization (minimize the importance of the stressful situation). Individuals rate their styles on a 100-point scale on eight coping styles used by him/her in reducing stress. Then, they review functionality and dysfunctionality of these styles for different situations and develop more effective ways of coping.

Pareek (1983) proposed two types of coping strategies which people use as the ways of dealing with stress. One way is that the person may decide to suffer, accept or deny the experienced stress or put the blame on somebody (self or others) for being in that stressful

situation. These are passive or avoidance coping strategies and are termed as "dysfunctional" styles of coping. Another way is that the person faces the stress consciously and takes action to solve the problems themselves or with the help of other people. These are active approaches of coping and are termed as "functional" style of dealing which stressful situations.

Pareek (1983) has proposed eight coping strategies and styles: "Impunitive"; "Intropunitive"; "Extrapunitive"; "Defensive"; "Impersistive"; "Intropersistive": "Extrapersistive" and "Interpersistive". These strategies can be categorized into two types: dysfunctional and functional.

Endler and Parker (1990) have considered the coping response from a multidimensional perspective and have identified three coping styles: task-oriented, emotional-oriented and avoidance-oriented. *Task-oriented coping* emphasizes the achievement of problem resolution through purposeful efforts on cognitively restructure the problem or alter the situation. *Emotion-oriented coping* delineates a set of reaction (e.g., tension, anger) of a self oriented nature which occurs in response to a problematic events. *Avoidance oriented coping* involves reactions or responses which have the effect of destructive or diverting individuals attention from stressful situation.

The stress-strain relationship is a function of coping strategies or mechanisms used by the individual. *Adaptive coping* reduces stress and promotes long term health whereas *maladaptive coping* reduces stress but promotes long term ill-health. Positive thinking and problem

focussed responses in the face of stressors are normally referred to as adaptive coping strategies; negative thinking and avoidance responses are referred to as maladaptive coping strategies (Nowack, 1990).

Coping as Trait, Style or Process

In recent years much attention has been paid to the distinction between coping as trait, style, or process. A "coping trait" means that a person is disposed to engage in given coping behaviour under certain conditions. The more general the trait, the less it is limited to any particular situational context. Thus, a coping trait is stable tendency from which a prediction is made about how the person will cope in some or all types of stressful encounters.

"Coping style" refers to a characteristic way of handling situations. The term "style" as in Adler's "style of life", tends to imply a very broad and encompassing disposition. There is something about the connotation of style that suggests sustained, complex strategies for relating to the world. Many of the concepts related to coping style are derived from one particular theoretical formulation, namely psychoanalytic ego psychology. There are a large number of coping styles schemes which have been described and classified by the researchers as coping behaviour.

A "coping process" refers to (1) "what the person actually does in a particular encounter", and (2) "how what is done changes" as the encounter unfolds (Lazarus & Folkman, 1984; p.827), or from encounter to encounter when they are united by some common theme. Process is

analogous to 'state' because it refers to what actually happens in specific contexts, and to how it changes. By definition, process means change. State is evanescent so is process. To Burke and Weir (1980), coping process refers to "any attempt to deal with stressful situations when a person feels he must do something about them, but which tax or exceed his existing adaptation response pattern".

Approaches to Coping

Psychologists interested in "coping with stress" have carried out empirical studies by following three approaches to coping.

The first model is derived from *drive-reinforcement learning theory* and is largely centered on animal experimentation. From this perspective, coping consists of acts such as escape and avoidance, that successfully control aversive environmental conditions, thereby lowering the psychophysiological disturbance or degree of disequilibrium created by the aversive conditions. Among those using this model, primary theoretical and research interest is centered on a set of variables relevant to stress reduction, namely, the predictability and controllability of the environment, and feedback from the environment about the effects of coping. Earlier studies focussed objective environmental display, observable coping actions, and psychophysiological response, which includes both autonomic nervous system reactions and adrenal medullary and adrenal cortical hormonal secretions. These physiological changes are commonly assimilated into a unidimensional concepts of degree of disequilibrium or arousal.

The second model of coping is centered on *psychoanalytic ego psychology* concepts. Coping is understood as a set of ego processes which develop from infancy and are centered on ways of thinking about relationships between the self and the environment. The essential task of living or to survive and flourish in the human social environment, and this requires that instinctual drives be gratified while at the same time socially based dangers and constraints are managed realistically. This model of coping is hierarchical. Coping is regarded as the most advanced or mature set of ego processes; events are handled realistically and flexibly in such a way as to maintain and promote mental and physical health. Defense mechanisms represent more primitive, neurotic processes characterized by greater rigidity and poorer reality testing.

A third model of coping emphasizes *cognitive appraisal processes* and a fluid transactional, and process-centered approach to coping and its assessment. Coping is viewed as responsive to contextual variables, temporal factors, and feedback from the flow of events which affect adaptational outcomes. It is defined as efforts to manage demands that tax or exceed the person's resources. The word "mange" in this definition means that coping can include toleration of harm or threat, redefinition of past events, acceptance, and putting a positive light on the situation - a set of ways for managing oneself and one's thoughts and feelings as well as mastery of the environment. By referring to demands that tax or exceed resources coping is limited to conditions of stress in which one must mobilize to deal with new

situations and draw on resources not typically used, and is distinguished from automatized adaptational behaviours that draw upon readily available habits of response involving minimal effort. Two major functions of coping are delineated-problem-focussed and emotion-focussed - the latter representing forms of coping that include the traditional defenses.

It seems clear that denial/avoidant modes of coping have sometimes favourable and sometimes unfavourable outcomes. It is quite possible that what is more adaptive depends on when it in the course of a threat such coping modes are activated; early denial and numbing may be useful, if abondoned for more realistic modes of coping. Also the content and context of the threat itself for example, the type of trauma as a source of stress - may determine which mode of coping is more adaptive The actual cognitive processes involved in a given form of coping could also be important. Perhaps denial of fact, puts the person at greater risk for damaging outcomes than denial of the implications of the fact.

Coping styles or strategies can be classified into three categories

1 . Cognitive Coping strategies We can cope with a stressor or our emotions by problem solving, self talk, and reappraisal. Problem solving involves analyzing the situation to generate possible courses of action to evaluate the efficacy of the actions, and to select an effective plan of action (Janis & Mann, 1976). To continue with the hidden anxiety

(emotion-oriented, self as target), or which classes to drop to reduce worry (emotion-oriented, environment as target), or on how to enlist the aid of fellow students to study, (problem oriented, environment as target). Self talk refers to covert statements or thoughts that are used to direct our efforts at coping with the stressful event and its associated emotional arousal. This internal talk directs attention to relevant stimuli, facilitates the formulation and implementation of coping strategies and provides corrective feedback (Meichenbaum, 1977). Imagine some one is reclining in a dental chair and awaiting a root canal procedure. He might use the following self statements: "The dentist is a caring person: will take care not to hurt me:" (emotion-oriented, environment as target); "I'm really tense, need to take a couple of deep breaths to relax (emotion-oriented, self as target); May be I can make this easier by distracting myself with pictures on the ceiling" (problem-oriented, environment as target); or "I need to dévelop a plan to deal with this" (problem-oriented, self as a target). Reappraisal involves reducing the impact of a stressful event by altering how that event is interpreted. In other words, the event is given a different meaning. A student could deal with failure in examination by thinking. "The test was unfair" (problem-oriented, environment as target) or "I just had a bad day" (problem-oriented, self as target). The anger engendered by the failure could be reappraised by thinking, "The teacher is a real creep, I have a right to be angry" (emotion-oriented, environment as target), or "No big deal, this course isn't important anyway" (emotion oriented, self as target).

2. Behavioural Coping Strategies Persons also respond to stress behaviourally. There are four general classes of behavioural responses to stress: seeking information, direct action, inhibition action, and turning to others. Seeking information refers to gathering data on the nature of the stressor and on possible coping strategies. An individual faced with a diagnosis of cancer, for example may seek information about prognosis from a health care provider (Hann, 1977). Information thus provides useful instrumental coping strategies and enhances feelings of control and predictability. Direct action refers to overt verbal and motor responses that alter stressors or stress related emotional arousal. An individual with a sprained ankle may rest, take pain pill, or see a physician to find relief. An individual who has recently experienced the death of a loved one may busy himself in his work or look at old pictures to deal with this grief. Inhibiting action involves not doing something in order to reduce stress and emotional arousal. A person with a persistent cough may stop smoking. Avoidance of anxiety provoking situations would also fit in this category. For example, a person frequently misses his appointments with health providers because of the pain and embarrassment associated with these visits. The last class of behavioural coping, turning to others, has been traditionally labelled social support. The phrase "turning to others" is used here because it emphasizes the active, international nature of this coping strategy. Our relationship with other persons provide an important resource in dealing with stress. We can gain material, emotional and informational support from others. Material support includes money, goods and services

available from significant others (Cohen & Mckay, 1984). Emotional support is the feeling of being loved and valued by others and the opportunity to reciprocate their feelings (Cobb, 1976). Informational support is available when others make suggestions about the meaning of stressful events or recommendations of coping efforts (Cohen & Mckay, 1984). Berkman and Syme (1979) for example, found social support to be a modest but significant predictor of mortality, even when controlling for initial health status, health impairing behaviours and social status. These persons with few social ties had higher mortality rates, social support may also mitigate the negative effects of stress that have already occurred. A large proportion of the problems most frequently reported by persons with the disease are interpersonal. These include difficulty communicating with significant others about the cancer, speaking with family members about the future, and gaining information from health providers (Wortman & Dunkel-Schetter, 1979). Health providers, family, and friends can provide cancer victims with clarification and reassurance about what is happening, show love and caring, and assist in developing strategies to deal with the physical and emotional demands of cancer and its treatment. Social support also promotes recovery by enhancing adherence to physical and mental health. The timing and manner in which social support is offered significantly influence its impact. Well-meaning assistance that is not wanted is not helpful, social support is not a reservoir from which a person passively borrows but rather an interpersonal exchange in which both parties are active (Cohen & Mckay, 1984) social support may also have negative effects.

Avoidance Coping Strategies According to Holahan and Moos (1986), avoidance coping is a response to threatening situations when personal and contextual resources are scarce. Also when severe stressors persist, individuals may gradually lessen their use of problem solving coping and increase their reliance on avoidance strategies (Moos, 1992). In avoidance coping, a personality to reduce tensions by drinking more alcohol), eating more and take tranquilzing drugs (sleeping pills)

Thus, individuals experiencing stress have to do something to deal with this and what is done to deal is referred to as coping. There can be several types of coping strategies such as cognitive, behavioural, avoidance or turning to others. There is no agreement as to who will use a particular type of coping strategy and who will use certain others. Persons use a mixture of several coping strategies.

In sum, the extent to which people of Kashmir living in high and low risk conditions experience traumatic life stress and its potential damaging effects depend on both the kinds of events they encounter and the ways in which they appraise them. People generally seem to cope better with major life events that are normal and expected part of daily living than with traumatic life events that they did not expect to occur and are not prepared to manage. The extent to which stress is harmful will then depend in part on the appropriateness and effectiveness of the coping styles the individual chooses. With this as background, the present study will examine the type of coping styles adopted by the individuals of Kashmir living in high and low risk conditions.

Measures of Coping

In recent years assessments have tended to rely on questionnaires or face to face interviews. The most widely used coping scale is the Ways of Coping Questionnaire (Folkman & Lazarus, 1980). It has been revised and also modified by other researchers to examine coping in different domains. Six tools or questionnaires are available for assessing coping. The Million Behavioural Health Inventory (MBHI) consists of a 150 items self-administered questionnaire from which eight coping strategies may be derived (Million et al., 1982). These are essentially trait measures and consist of introversive, inhibited, cooperated, sociable, confident, forceful, respectful and sensitive. The Miller Behavioural Style Scale (MBSS) has also been used as an assessment tool in coping. It examines the strategies monitoring and blunting by obtaining responses to four hypothetical stress situations (Miller, 1985). Viney and Westbrook (1982) report technique where patients rank order their likelihood of using a particular item which has been selected from six different coping strategies (action, control, escape, fatalism, optimism, interpersonal). This provides a trait measure of the tendency to utilize a particular strategy. Pareek (1983) developed an instrument know as role of PICS which measures two types of strategies know as dysfunctional and functional to cope with stress. Dysfunctional styles of coping include impunitive, intropunitive, extrapunitive, and defensiveness. Functional styles of coping include-impersistive, intropersistive, extrapersistive and interpersistive.

Dysfunctional and Functional styles of coping imply avoidance-oriented and approach-oriented behaviours. Folkman et al., (1986) report eight factors in their factor analysis of their revised questionnaire. These factors are: problem focussed coping, wishful thinking, detachment seeking social support, focussing on the positive, self-blame, tension-reduction and keeping to oneself. Six of these factors represent emotion focussed coping, one problem focussed coping and the last a mixture of both modes of coping. The Cope Scale developed by Carver et al., (1989) is also used to assess coping styles and strategies. The cope scale comprised 30 items which measures fifteen scales, namely, active coping, planning, seeking instrumental social support, seeking emotional social support, suppression of competition activities, religion positive reinterpretation and growth, resistant coping , acceptance, focus on and venting the emotions, denial, mental disengagement, behavioural disengagement, alcohol / drug, and humour.

There is evidence that there are individual differences in preferences for coping strategies. Individual ways for coping strategies provide us the guideline how to cope with stress in different situations. A strategy or style that would increase stress for one person may reduce stress for another. A person who copes with a stressful situation depends upon his or her temperament, motives, intelligence and personality which help him to develop unique, personally meaningful strategies. There is a need to develop and encourage coping style that will be most adaptive for each person. Social support is one of the coping strategy which fosters continued growth.

The concept of traumatic stress and coping styles discussed above are mutually related. Both are equally important and play a vital role in Kashmiri people's lives. The present study is an arduous effort to focus on Kashmiri people living in high and low risk conditions by giving improtance to these psychological concepts as a whole.

Chapter Two

REVIEW OF RELEVANT STUDIES

This chapter presents an overview of recent studies in the field of traumatic stress. The investigator classified studies in several areas namely, trauma and psychopathology, effects of trauma, therapy for traumatized individuals, trauma and coping. Studies on coping styles are also reviewed in this chapter.

Trauma and Psychopathology

This is a burgeoning area of scientific enquiry to understand traumatic events. Researches falling in this area have led to the identification of psychological symptoms and disorders frequently experienced in response to traumatic events. Although a number of studies have examined psychological consequences of traumatic events such as holocaust, war, terrorism, captivity, torture, political migration, living as a political refugee and assassination, etc. This area of enquiry is rarely studied within the domain of traumatic stress.

Ulmann and Siegal (1994) examined how recent life events, chronic strains, and social supports affected the overall level of symptoms reported by survivors of traumatic events. Risk of increased post-traumatic stress symptoms following traumatic events exposure was associated with other life events, sexual assault and household strains. Level of post-traumatic stress symptoms varied according to the type of traumatic event reported after adjusting for demographic

factors. Women and younger adults reported more traumatic stress than other subjects.

Wyshak (1994) examined changes in the reporting of trauma events in relation to the reporting of severity of symptoms of psychiatric distress among refugees from South East Asia. 30 subjects were interviewed twice using a questionnaire which included enquiry about traumatic events and psychiatric symptoms. The changes in answers in interviews were assessed. The number of traumatic events correlates positively with the severity of symptoms. The severity of symptoms increased from time 1 to time 2 for 23 of the 30 symptoms. The reporting of the traumatic events varied between times 1 and 2.

Sadavoy (1997) reviews the literature on the epidemiology, symptom picture and treatment of elderly patients who have encountered serious psychological trauma in life. Data are predominantly derived from studies of aging, holocaust survivors and combat veterans from world War II, the Korean conflict in Vietnam. Results show that survivor syndromes persist into old age but patterns of expression vary. Holocaust survivors appear to have adapted well to instrumental aspects of life whereas combat warriors may show less functional life adaptation. Persistent symptoms in all groups include marked disruptions of sleep and dreaming, intensive memories, impairment of trust, avoidance of stressors, and hightened vulnerability. The various types of age associated retraumatization. There is a deficiency of controlled treatment studies of traumatized elderly patients but

successful group, individual, and family clinical interviews have been described.

Cunningham and Cunningham (1997) examined the incidence of psychological and medical symptomatology, torture and related trauma in a sample of 191 refugee clients of the service for the treatment and rehabilitation of torture and trauma survivors (STARTTS) in Newsouth Wales, Australia; and identified patterns of current symptoms, patterns of torture and trauma experiences and the relationships between symptoms and experiences analysis of STARTTS client records permitted. The coding of the presence/absence of 41 medical and psychological symptoms and of 33 torture and trauma experiences 6 factors were extracted for both the symptoms and trauma experiences; the first symptom factor was labelled as core post traumatic stress disorder (PTSD). Threats and humiliation and being forced to watch others being tortured best predicted scores of this factor. Another core PTSD is the dominant factor in symptomatology, co-morbidity is high with another 3 symptom factors emerging as meaningful.

Kubany et al. (1997) describe the development of a survey to systematically assess idiosyncratic sources of guilt across the spectrum of events that are potential sources of trauma related guilt from the war zone. Results indicate the surveys temporally stable, substantially correlated with other measures of guilt, and highly correlated with measures of PTSD and depression. Findings confirm that many Vietnam veterans have multiple sources of severe war related guilt. The survey may have important clinical utility for problem identification.

Gorst-Unsworth and Goldenberg (1998) examined the importance of social factors and of trauma factors in producing the different elements of psychological disorders. Adverse events and level of social support were measured in 84 male Iraqi refugees. Various measures of psychological morbidity were applied. Social factors in exile, particularly the level of affective, social support proved important in determining the severity of both post-traumatic stress disorder and depressive reactions, particularly when combined with a severe level of trauma/torture. Poor social support is a stronger predictor of depressive morbidity than are trauma factors.

Abed (1998) suggests that an understanding of the interaction between the nations characteristics and the characteristics of the trauma may offer a better chance of predicating the level of risk of developing a particular psychiatric syndrome following traumatic and stressful events.

Roemer, Orsillo, Borkovec and Litz (1998) investigated the relationship between the retrospective reports of emotional responses (fear, helplessness, and horror) and disrupted emotional responses (numbing) at the time of the potentially traumatizing event and report of PTSD symptomatology among 244 undergraduates. The authors found that, of the DSM-IV criteria, only helplessness was significantly correlated with PTSD symptomatology. Results of traumatic emotional numbing uniquely predicted subsequent PTSD symptomatology beyond coincident emotional responses.

Husain et al. (1998) examined the relationships between gender loss of family members, and perceived deprivation to the development of post traumatic stress symptoms in children and adolescence during siege conditions in Sarajevo. 791 students were surveyed to assess symptoms of traumatic stress and level of deprivation. Results show that girls reported more stress than boys. Loss of family member and deprivation of basic needs were associated with more symptoms.

Wozniak et al. (1999) examined the relationship between trauma and attention deficit and hyperactivity disorder (AD/HD) and evaluated whether AD/HD increases the risk of trauma, the risk of post traumatic stress disorder (PTSD), or the risk for trauma associated psychopathology. Data from a longitudinal sample of 260 male children and adolescents with and without AD/HD were examined. All were evaluated comprehensively with assessments in multiple domains of functioning including systematic assessment of trauma and PTSD. Comparisons were made between traumatized and non-traumatized youth with and without AD/HD. Significant differences were not found between AD/HD and control children either in the rate of trauma exposure or in the development of PTSD. Although trauma was associated with the development of major depression, this effect was independent of AD/HD status. In contrast, bipolar disorder at baseline assessment was a significant risk factor for subsequent trauma exposure.

Chung, Easthope, Chung and Clark-Carter (1999) examined the extent of psychological distress and the association between personality

variables and psychological distress among individuals who had been exposed to an aircraft disaster in Coventry, UK. 82 residents were randomly chosen for interviews in which they were assessed using the impact of event scale, the general health questionnaire (GHQ), and Eysenck Personality Questionnaire-R short scale. The results showed that Coventry residents' scores reached similar levels of intrusion and avoidance compared with standardized samples and the Lockerbie samples. 52% reached the GHQ case level score, which was again similar to the Lockerbie residents. The Coventry residents were significantly less extroverted and neurotic than standardized samples. Stepwise multiple regression showed that there were associations between intrusion and neuroticism and intrusion and extroversion as well as between avoidance and neuroticism.

Harvey and Bryant (1999) examined the initial pilot comparison of the incidence and nature of acute stress disorder (ASD). Across four trauma group survivors of motor vehicle accidents, severe burns, industrial accidents and non-sexual assaults, 102 old patients completed the Acute-Stress Disorder Interview. The overall incidence of ASD and the incidence rates of each trauma type were consistent with previously reported incidence rates of ASD. The majority of sub-clinical diagnosis did not meet criteria for the dissociative cluster. It was found that burn patients reported more fear and numbing than other trauma patients. The finding that numbing and depersonalization had relatively strong positive predictive power is consistent with the notion that acute dissociative mechanisms prevent the processing and resolution of

trauma related information and thereby contribute to post-traumatic psychopathology.

Gershuny and Thayer (1999) have reported that in general, findings have revealed fairly strong and consistent relations among the constructs of trauma dissociation and trauma related distress (e.g. post-traumatic stress disorder, borderline personality disorder, bulimia). Individuals who have experienced a traumatic event are more likely to dissociate than individuals who have not and individuals who experience more dissociative phenomenon (DP) are more likely to experience higher levels of trauma related distress (TRD). The authors theorized that DP and subsequent TRD may relate to fears about death and fears about loss or lack of control above and beyond the occurrence of the traumatic event itself. Such fears about death and loss /lack of control may also help differentiate traumatized individuals who psychologically suffer to varying degrees.

Punamaki (1999) examined how mood changes from night to morning, and how dysphoric dream contents associated with this change among children who live in traumatic environment and their controls from peaceful area. Three hypotheses have been set for the present study. First, the results confirmed that mood change from evening to morning is a general dream function. The mood change was rather associated with what and whom the children dream about. Second, the hypothesis of the trauma group showing less change in dysphoric dream content and in the intensity of negative morning mood across a period

of time of 7 days was not confirmed. Third, it was hypothesized that there is a stronger association between pre-sleep negative mood and dysphoric dreams as well as between the dysphoric dreams and negative morning mood among children living in traumatic environment than among children from peaceful area. Contrary to the hypotheses results from the trauma group revealed a reverse association between evening mood and dream contents.

Prigerson et al. (1999) developed and tested diagnostic criteria for traumatic grief. Recover Operator Characteristics (ROC) analysis were used to test the performance of the proposed criteria. All 306 widowed respondents at 7 number postloss ROC analysis indicated that three or four separation distress symptoms had to be endorsed as at last sometime 3 and 4 of the final 8 traumatic distress symptoms (e.g., numbness, disbelief, distrust, anger, sense of futility about the future) had to be endorsed as at least mostly 2 to yield a sensitivity of 0.93 and a specificity of 0.93 for a diagnosis of traumatic grief.

Corneil et al. (1999) compared duty related trauma experiences and the prevalences post traumatice stress in US. and Canadian fire fighters. Both samples reported relatively numerous and frequent post-traumatic symptoms, and the rules of self-report. PTSD prevalence did not differ significantly. However, analysis of departmental records for respondents' previous year on duty revealed significant differences in both frequencies and categories of traumatic incident, exposure. Some of the vulnerability and moderating risk factors associated PTSD cases differed between the US and Canadian samples.

Favaro, Maiorani, Colombo and Taso (1999) investigated the presence of traumatic experiences during and after the war in Bosnia. The presence of PTSD or major depression disorders (MDD) was determined using the structured clinical interview of DSM IV. The results suggest that refugees from former Yugosalavia are at high risk for trauma related psychiatric disorders. The rate of PTSD in the sample was 50% and the rate of MDD was 35% Subjects with PTSD reported a significantly higher number of traumatic experiences compared to the rest of the sample. A non-significant association was found between dissociation and the number of different traumatic experiences and between association and PTSD. These findings support the hypothesis that despite a common link with traumatic experiences, dissociation and PTSD two distinct types of symptoms emerged.

Soloman and Heide (1999) have made an attempt towards developing a more effective conceptualization of psychological trauma. The authors build a framework based on the work of a psychiatrist L. Terri who distinguished between Types I and Type II psychological trauma by proposing the Type III category of trauma. Type III trauma occurs when an individual experiences multiple, pervasive, violent events beginning at an early stage and continuing over a long period of time. Diagnostic criteria includes alterations in memory and consciousness frequently including dissociation, emotional numbing, major developmental deficits, poorly developed, often fragmented sense of self; a core belief that he or she is total flawed and has no right to be alive; a sense of hopelessness and shame; trust issues that interfere

with normal relationship and no concept of future. Treatment of individuals who have sustained Type III trauma is more complex and demanding related to survivors of Types I and II trauma.

Martinez-Taboas and Bernav (2000) examined the possible relationship between different types of traumatic experiences and the self report of dissociative experiences, depressive symptoms and general psychopathology in a sample of 198 undergraduate students between the ages of 17 and 42 years. The study also examined the psychometric properties of the dissociative experiences scale in a Latin sample, Results support the hypothesis that those individuals who report frequent and severe traumatic experiences are also the most likely to experience psychological malice. Those reporting frequent and severe traumatic experiences score higher on Dissociative Experiences Scale. The authors conclude that individuals with a marked history of trauma and abuse are more likely to use dissociative defenses as a coping response.

Bolton et al. (2000) investigated the long term course of general psychopathology following trauma in adolescence. The survivors of a shipping disaster showed raised rates of diagnosis in a range of anxiety and affective disorders during the follow up period. The highest rates were among the survivors who had developed post traumatic stress disorder and those surviving who had not were generally similar to control group. All set of anxiety and affective disorders varied between being indefinitely close to the controls. Onset of anxiety and affective

disorders varies between the survivor and control groups due to continued distress among the survivors still suffering form PTSD and to a lesser extent among those who had recovered form PTSD.

Effects of Trauma

This section reviews the current literature on the nature of traumas in people and their short term and long term effects. The age, developmental level, family and sociocultural factors are the important mediators of the effects of trauma on people. Recent research has shifted the focus from psychopathology to long term effects on psycho-social and cognitive development of traumatized individuals.

Klingman (1994) investigated the impact of cumulative trauma on 253 Israeli 5th and 6th grade children and risk from missile attacks during the Persian Gulf War 1991. During the 5th week of the war, the subjects were asked to write in their classrooms a short composition about their personal experience since the beginning of the war. Random sample of 80 compositions was coded by school counsellors. The major concern of the study was the feasibility of employing a school based, easy to administer, assessment tool (i.e. a composition as both research and clinically oriented assessment procedure). The most noted experiences reported were subjects active behaviour in the sealed room the role the mass media played and the war as a source of stress and anxiety respectively. More fears were expressed by boys than girls. The subjects composition may have considerable practical value for group based assessment in community disaster situations.

Elbedour (1994) explored how children construct their experiences of justice and injustice and how abuse related exclusively to the meanings assigned to these constructs. The effects of trauma are most apparent when significant and generalized others (i.e. family, community, culture) cannot maintain the human contracts that bond people, define social order and ensure justice. The psychological adaptation of the child is also shaped by the way the legal system responds to the plight of the child and how the traumatic event is interpreted according to ethical standards that the child has developed. Trauma can be especially acute if the parents, community and or the legal system do not expect in some way to restore the child's sense of justice.

Hodgkinson and Shepard (1994) attempted to examine the impact of disaster related stress on helpers offering psychological support to victims of two major disasters and to identify potential moderating factors. The responses of psychological helpers in disaster support work (DSW) appeared to be determined by a complex interaction between personality characteristics (coping style, hardiness), DSW related factors (impact of client contact and role issues), now DSW related factors (prior life events). 60% of subjects experienced significant levels of symptoms during their first year of DSW and follow up data suggest that levels were maintained 12 months after the initial survey.

Gurwitch, Sullivan and Long (1998) studied the impact of trauma and disaster on young children. The authors reported that the

characteristics of stress in young children are similar to those of older children and adults, but their relations are unique.

Yehuda, McFarlane and Shalev (1998) summarizes the findings from recent studies that examined the acute and longer term biological response to traumatic stress in people appearing to the emergency room immediately following trauma exposure. In the aggregate these studies have demonstrated increased heart rate and lower cortisol levels at the time of the traumatic events. In those who have PTSD at a follow up time compared to those who do not. In contrast certain features associated with PTSD such as intrusive symptoms and exaggerated startle responses are only manifest weeks after the trauma. The findings suggest the development of PTSD may be facilitated by a typical biological response in the immediate aftermath of a traumatic event, which in turn leads to a maladaptive psychological state.

Wilson and Moran (1998) have advocated that traumatic events adversely affect not only the psychological dimension of the self but also the faith system and spirituality which give meaning to one's life. In this article, the author examines the effect of severe trauma and post-traumatic stress disorder (PTSD) on human spirituality and faith. The psychological trauma caused by natural disasters, accidental disasters, disaster of human origin and violence often leaves the spiritual domain in disarray. The article offers practical considerations for mental health practitioners and pastoral counsellors from whom the victims of severe trauma seek help.

Breslau, Chilcoat, Kessler and Davis (1999) examined the effects of previous exposure to trauma. 1922 individuals were interviewed by telephone to record life time history of traumatic events specified in the DSM-IV as potentially leading to PTSD. The PTSD was assessed with respect to a randomly selected index trauma from the list of events reported by each respondent. Results showed that history of any previous exposure to traumatic events was associated with a greater risk of PTSD from the index trauma. Multiple previous events had a stronger effect than a single previous event. The effect of previous assaultive violence persisted over time with little change. When they examined several features of the previous exposure to trauma, the authors found that subjects who experienced multiple events involving assaultive violence in childhood were more likely to experience PTSD from trauma in childhood, Furthermore, previous events involving assaultive violence, single or multiple in childhood or later on were associated with a higher risk of PTSD in childhood. Thus, previous exposure to trauma signals a greater risk of PTSD from subsequent trauma.

Janoff-Bulman and Berger (2000) explore the ways in which appreciation is experienced in the aftermath of trauma, However, in order to understand survivors' experiences of appreciation - the positive side of trauma, we must familiarize ourselves with the negative side, with the losses that accompany traumatic experiences, for the two sides of trauma are closely linked. We will then focus more specifically on the psychological processes or mechanisms that underlie instances of

value creation in order to provide a basis for understanding more generally, the psychology of appreciation. Topics include, the negative side of trauma; loss and vulnerability, the positive side of trauma: appreciation and value creation; the importance of attending and noticing, (appreciating life itself, mortality as a basis for valuing, appreciating others: the role of reciprocal valuing, appreciating the self effort based discovery of personal strength; towards a psychology of appreciation, survivor's fundamental ambivalence).

Miliora (2000) explored the effects of cultural races on a persons sense of self. Racism assault victims with experiences of being perceived as less than human by the social milieu. Such experiences can literally erode self-esteem and ambition and cause a "depression of disenfranchisement" hereby one feels objectly ungrandiose. The author utilizes a literary example and one from clinical experience to illustrate how chronic experiences of antipathy derived from cultural racism erode a person's sense of self by virtue of the disenfranchisement of grandiosity.

King and Miner (2000) examined the potential benefits of writing about the positive side of painful life events. 118 psychology students were randomly assigned to 1 of 4 cells (writing about trauma, not writing about trauma, writing about perceived benefits, or not writing about perceived benefits) and instructed to write about 1 of 4 topics, (a) trauma only- their most traumatic life experience, (b) trauma plus perceived benefits, a traumatic life experience and how they have grown

and / or benefited as a result of the experience, (c) perceived benefits only, the positive aspects of and how they have grown or benefited as a result of some traumatic experience or loss, and (d) control condition, participants wrote about their plans for the following day and description of their shoes. Participants also completed questionnaire, measures of subjective well-being and released health centre information for a year. Those who wrote only about trauma or perceived benefits showed significantly fewer center visits for illness three months after writing. Additionally five months after writing, the trauma only and perceived benefits only groups maintained a difference from the control group.

Shaw (2000) presents an overview of the psychological effects of trauma on children and adolescents with specific attention to the epidemiology of traumatic experiences albeit a single event trauma or a chronic process trauma, the spectrum of clinical presentations, psychiatric and psychological comorbidities as well as assessment and therapeutic principles. In addition to the child's psychological response to the traumatic stressor, communities are often devastated by natural or man made disasters. The interactions between the child's response with the family and community response as well as community interventions are discussed.

Coping With Trauma

Lingma and Kupermintz (1994) investigated the relationships of Coping responses, self control and trait anxiety in Israeli University

students during the 1991 Gulf war. 35 male and 58 female subjects responded to a battery of questionnaires at the end of the war to assess these variables. Their responses regarding their experiences in prepared sealed rooms during gulf war missile attacks were characterized by attempts to help others and relatively low emotion focussed reactions. Factor analysis suggests a three factor structure of response modes instrumental, emotion-focussed and bluntiing like. Self control was associated with a lower intensity of the emotion focussed mode. Trait anxiety did not correlate with any of the response modes. Female subjects reported more emotion-focussed responses.

Davis et al. (1995) were concerned with how a negative outcome could have been avoided. Counterfactuals (CFS) that were generated by victims of traumatic events were examined to elucidate their significance for the coping process. In study I, 93 subjects were interviewed, 4-7 years after the loss of a spouse or child in a motor vehicle accident. In study II, patients were interviewed at three weeks (228 subjects) and 18 months (124 subjects) following the death of a child from sudden infant death syndrome, Across both studies, the CFS were commonly reported: the focus of CFS was typically on one's own in (actions) rather than on the behaviour of others; and more frequently subjects were undoing the event; the more distress they reported. People coping with traumatic events appear unhindered in their ability to generate CFS.

Harvey, Stein, Olsen & Richards (1995) investigated 45 people's self-report accounts of loss and recovery from the 1993

flooding in Illinois, Iowa, Missourie. Subject's narratives described reliance on activities such as developing an account of the situation, private reflection, and prayer, confiding in close others, and community volunteer and kin support in coping with these losses. Subjects also reported that marriages and close relationships that were problematic before the flooding worsened. Relative to other subjects, subjects from Hulls, Illinois reported more rapid and effective accommodation to their losses and rapidly initiated steps to rebuild and restore homes and lives devastated by the flooding. The narrative evidence pertinent to coping is interpreted in terms of the contribution of account making, confiding in and social support systems toward the amelioration of psychological impairment due to major losses.

Meszen (1997) suggests an interactional approach to the description and explanation of coping with stress. It is presumed that coping behaviour like other forms of human behaviour depends on an interaction between situational and individual factor. From among individual factors, coping style is selected as a dispositional variable which indirectly determines coping behaviour. Of the situational factors, controllability is regarded as a variable of special importance for coping behaviour, because in controllable situations information processing concerning the stressor is adaptive, which in uncontrollable situations it has little value. Two studies on coping with somatic illness are presented as examples of applying the interactional approach in research on coping with stress. In the second study, 259 patients participated. Their coping style was evaluated using an adaptation of the Miller Behavioural Style

Scale. They represented illness differing in controllability. Results confirm the superiority of the interactional approach compared with an approach including only the situational factor in the explanation of coping behaviour.

Liabre and Hadi (1997) tested hypothesis about the role of social support in the relation between trauma from the Gulf crisis experience and psychological or health distress 2 years after the crisis. Participants were 151 Kuwaiti boys and girls exposed to high or low levels of trauma during the crisis. Children exposed to high levels of trauma had higher PTSD and depression and more health complaints than controls. Social support did not mediate the relation between trauma and distress. However, social support and sex function jointly as moderators of trauma on distress. Social support was shown to buffer the effect of trauma in girls but not in boys. Boys, however, reported lower levels of support than girls.

Kiser, Ostoja & Pruitt (1998) tried to understand how families evaluate stressors and their own coping resources and how this process guides their response to stress. Characteristics associated with successful family adaptation to stress than are outlined in relation to a number of both normative and unexpected stressors. Most families at some point experience stress in the context of normative transitions such as changes in family composition through with, naturation or family break-up. Severe unexpected stressors that place significant strain on family functioning include serious illness, death, violence, and both natural and man made disasters.

Solomon et al. (1998) examined the implication of attachment style in both immediate coping and long term adjustment of prisoners of war (POW). 167 Israili exprisoners of war and 184 matched controls filled out a battery of questionnaires 18 years after the Yom Kippur war. Subjects were questioned about their subjective experience of captivity, current mental health status and characteristic attachment style. Secure individuals, who reported lower levels of suffering, less helplessness, and more active coping during captivity exhibited better long term adjustment. Avoident ex-POW who reported helplessness and hostility, and ambivalent individuals who felt abundant and vulnerable, reported long term maladjustment.

Beninght et al. (1999) employed social cognitive theory and conservation of resources theory to understand individual differences in psychological response to natural disaster. Coping self-efficacy, lost resources, social support and optimism were assessed along with demographic variables in predicting distress following Hurricane Opale. Multiple regression analysis showed that coping self-efficacy was the strongest predictor of general distress and trauma related distress. Loss of resources and gender were also important predictors of general distress. Path analysis showed that lost resources directly influenced general distress, social support, optimism, and coping self-efficacy. These analysis also indicated that coping self-efficacy perceptions moderated the relationships between the loss of resources and trauma related distress, social support and both trauma and general distress, and optimism and both types of distress.

Almqvist and Hwang (1999) studied the variety of coping strategies of both emotion and problem-focussed coping used by the Iranian refugees children and parents when living in Sweden. Both children and parents used a variety of coping modes, addressing different topics, such as previous traumatic experiences, loss of social network and acculturative adjustment. Examples of children's narratives are given to illustrate how they coped with adaptive challenges in exile. Parents generally described problem-focussed coping such as moving to better living areas, while children mostly described emotion-focussed coping, such as positive thinking and day dreaming. Parents deliberately facilitated or discouraged different coping strategies in their children and were also greatly influenced by their children's success or failure in coping.

Allen, Whittlesey, Pfefferbaum and Ondersma (1999) reported common illness and coping mechanisms of a group of mothers and grandmothers whose children were killed in the day-care centre of the bombed, Murrah building in Oklahoma city and examined the community these women formed. Grandmothers were included because they were often the major or the only parenting person these children had. Subjects expressed two types of coping, problem-focussed and emotion-focussed. Lessons from these women in fostering resilience include developing a disaster plan that recognizes specific sub-groups, negotiating therapeutic contracts relevant to such women's needs, minimizing development of long term pathogenic identities and life

narratives and enhancing sense of continuity dealing with specific sources of rage and resentment and keeping the family in focus.

Allen, Dlugokinski, Cohen, and Walker (1999) studied emotional processing, understanding and coping behaviour of approximately 6500 elementary school children in Oklahoma city after the bombing of the Murrah building. Also, art work created by children across the US in response to the bombing was analyzed. Younger subjects were least likely to understand what was going on and were most likely to be confused, to have the highest number of wrong facts and to use avoidance as a coping mechanism. Fear, confusion and shock were most powerful immediately after the event and sadness gained as fear waned. Time gave subjects a chance to absorb the event, process it, and recover from the shock. Artwork was assigned to two categories: children's feeling (sadness, regret, anger, confusion, and hope) and children's vision for healing.

Davis et al. (2000) reviewed existing resources that addresses the assumptions that (a) people confronting certain traumatic losses inevitably search for meaning, (b) overtime most are able to find meaning and put the issue aside, and (c) finding meaning is critical for adjustment or healing. Additional evidence from a study of 124 parents coping with the death of their infants and a study of 93 adults coping with the loss of their spouse or child to a motor vehicle accident was also provided. Results of the studies indicate that (a) a significant subset of individuals do not search for meaning and yet appear relatively well

adjusted to their loss; (b) less than half of the respondents in each of these samples report finding any meaning in their loss, even more than a year after the event and (c) those who find meaning, although better adjusted than those who search but are unable to find meaning, do not put the issue of meaning aside and move on rather they continue to pursue the issue of meaning as fervently as those who search but do not find meaning.

Yeh and Wang (2000) assessed coping attitudes, sources and practices within and across a sample of 470 Asian-American college and graduate students from 4 ethnic groups; Chinese, Korean, Philippine, and India. The authors found that Asian-Americans tended to endorse coping resources and practices that emphasized talking with familial and social relations rather than professionals such as counsellors and doctors. Korean Americans were significantly more likely to cope with problems by engaging in religious practices.

Therapy For Traumatized Individuals

Psychologists have discovered some useful therapeutic strategies to heal and treat the inner world of individuals suffering form the traumatic stress. However, psychological approaches adopted for the treatment of traumatized individuals are related to types of traumatic stress.

Straker and Moosa (1994) examined the responses of a group of 10 psychologists and 5 social workers to therapy sessions with survivors of South Africa's political repression and civil conflict. In

interviews, the subjects expressed feelings of powerlessness, anger fear, and anxiety related symptoms to the therapist. Data show that both the potential for retraumatization of survivors and the potential for direct traumatization of the therapists intensify these reactions and complicate their resolution. The similarities and differences between this particular context and other contexts of trauma within which therapists may work are discussed.

Murray and Daniel (1994) compared 60 undergraduates, vocal expressions of feelings about interpersonal traumatic and trivial events to 60 undergraduates written expressions of such feelings in 20 minute sessions over a 4-day period. Similar emotional processing was produced by vocal and written expression of feeling about traumatic events. The painfulness of the topic decreased steadily over the 4-days. At the end, both groups felt better about their topics and themselves and also reported positive cognitive changes. A content analysis of the sessions suggests greater overt expression of emotion and related changes in the vocal condition. There was an upsurge in negative emotion after each session of either vocal or written expression. Results suggest that psychotherapy ameliorated the negative mood.

Seligman (1995) discusses the use of creative therapy with victims of a prolonged life threatening situation, using examples of the use of threats as a coping mechanism within concentration camps during the holocaust. The characteristics of life threatening situations and the coping process are discussed, and examples of performance and personal

testimonies of the use of drama in the concentration camps are presented.

Fischman (1998) explored metaclinical implications of psychotherapy with individuals traumatized by violent political repression with an emphasis on ethical concerns in treatment. Issues addressed include the relevance of the sociopolitical context in the conceptualization of the trauma, the challenge of transcending cultural frameworks, the clinicians role in the reversal of collective denial, the interplay of motivation and counter transferance, and the impact of questions of purpose and meaning in both survivors and clinicians interacting with trauma.

England (1988) advocates that there is, however, as yet little independent evaluation of the notions and therapeutic practices which inform humanitarian interventions in refugees mental health. This paper problematizes two central issues in these interventions: the role of past experiences in refugees present well-being, on the one hand, and the need to verbalize trauma in a therapy, on the other. An alternative approach to refugees mental health draws on current theoretical insights into non discussive bodily practices. The paper substantiates these insights by focussing on the therapeutic salience of funerals and spirit exorcism among Mozambican refugees in Malaus. By exorcism, the vengeful spirits of those who had died during the war, refugees were also healing their war trauma. It was not so much the loss as the difficulty in observing a full range of rituals that characterized refugees' predicament.

Schweidson (1998) posits that patients traumatized by events beyond the limits of human experiential educability often revealed a shattered self with no continuous personal core. These events seem to have occurred without a witness, possibly because their inhumanity caused the subject to disappear while the events were taking place. Such patients suffer from their sudden emergence of dissociate sets of memories which seem to have registered the entire circumstances of the trauma in a frozen state. The therapist's interventions seem to have no impact at these moments. This may be because there is a self other that the patients i.e. present at a scene which belongs to a past that never ceases to recur. These enactments of post-traumatic events reveal a self condemned to disbelief whenever testifying to an inhuman situation devoid of any subjectivity. Vignettes from the psychoanalytic treatment of a patient who suffered from traumatic memories will illustrate the points above. The testimonies of homeless children and of holocaust survivors also point to this silencing of voices bonded by an inhuman past.

Kilborne (1998) explored what makes a child (or an adult) "ready to be blown up" by external events and with the effects of experiencing such explosive fragmentation. In particular, childhood trauma as these appear in adult treatment, are also addressed. Since perceptions of trauma are necessarily governed by the means by which trauma is known, analysis as treatment can broaden our understanding of trauma in ways that other treatments cannot. In treating and studying

trauma analytically it is impossible to avoid the subject of splitting and identification with the aggressor which can serve to sharpen awareness of the effects of the analytic situation on the patient and elucidate the nature and function of psychic pain. Two cases are explored which exhibit the effects of splitting in reaction to trauma. Analytic treatment, including analytically oriented psychotherapy constitutes an indispensable means of understanding trauma precisely because it aims at uncovering unconscious motivation and conflict as these are revealed, understood and worked through in both the transference and the counter transference and because it is uniquely able to work through layers of noxious shame surrounding the trauma-like star tissue.

Silove (1999) suggested that a focus on intervening psychosocial adaptive systems may assist in delineating more clearly that pathways that determine whether traumatized persons achieve psychosocial resolution or are at risk of ongoing psychiatric disability. A model is proposed which suggests that torture and related abuses may challenge 5 core adaptive systems subserving the functions of "safety", "attachments", "justice". "identity role", and "existential meaning". It is argued that a clearer delineation of such adaptive systems may provide a point of convergence that may link research endeavours more closely to the subjective experience of survivors and to the types of clinical interventions offered by trauma treatmental services.

Nicholas and Forresters (1999) established the connection between a social constructionist perspective with a psychodynamic one

to discuss the problem of trauma and its treatments. They argue that effective treatment of traumatic physical, sexual and psychological abuse must do more than alleviate the pain of the sufferer. Factors that cause and perpetuate abuse must be addressed by the abused person in conjunction with other nontraumatized persons who may have been abusive or passive in the face of abuse. The case examples of adult survivors of childhood trauma showed how such groups get therapeutic benefits for the traumatic abuse survivor and others simultaneously.

Grame et al. (1999) emphasize the growing necessity for psychotherapists and clergy to collaborate in the treatment of clients with psychological trauma. The authors draw attention on their personal treatment experience to illustrate the spiritual and religious issues of clients and the necessity for spiritual and religious assessment plans for their population.

Chaffin and Hanson (2000) opine that cognitive behaviour therapy shows promise in treatment with the children who are multiply abused and experience trauma as a chronic part of their lives. The authors also advocate that adaptations must be made to consider the special needs of children who suffer multiple and ongoing traumatization.

Research Objectives

Though every research study is based on some hypothesis. No research is done without formulating any hypothesis. Since the present study is not based on the findings of previous research and it is

exploratory research and also it is a new field in the field of 'stress and coping', it is therefore the investigator did not formulate any research hypothesis. The main emphasis is to explore the traumatic stress and coping styles among Kashmiri people living in high and low risk conditions and to depart from the existing trend in the area of stress and coping. Instead of formulating hypotheses we have set research objectives which are presented below.

The main research objectives of the present study are :

1. to develop the traumatic stress inventory.
2. to identify traumatic stressors among Kashmiri individuals living in high and low risk conditions.
3. to determine differences between males and females living in high risk conditions on traumatic stressors.
4. to determine differences between males and females living in low risk conditions on traumatic tressors.
5. to determine differences between males living in high and low risk conditions on traumatic stressors.
6. to determine differences between females living in high and low risk conditions on traumatic stressors.
7. to develop coping styles inventory.
8. to identify coping styles used by the Kashmiri individuals living in high and low risk conditions.

9. to determine differences between males and females living in high risk conditions on coping styles used to cope with traumatic stress.

10. to determine differences between males and females living in low risk conditions on coping styles used to cope with traumatic stress.

11. to determine differences between males living in high and low risk conditions on coping styles used to cope with traumatic stress.

12. to determine differences between females living in high and low risk conditions on coping styles used to cope with traumatic stress.

Chapter Three

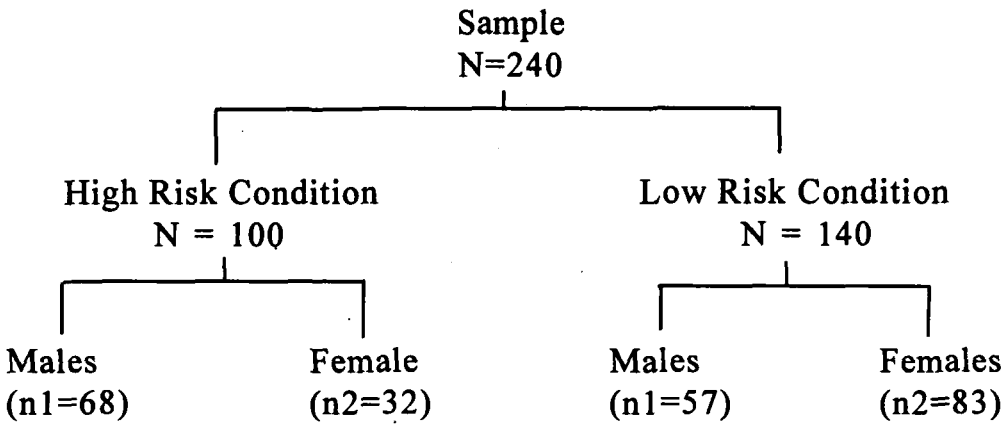
METHOD

This chapter deals with the methodology of the present study. An attempt is made to present the statement of the problem, sample, tools, procedure of data collection and statistical treatment of the data.

Statement of the Problem The present investigation is an attempt to study the behaviour which people of Kashmir are facing i.e. traumatic stress and how they cope with it by using different coping styles.

Sample The sample for the present study consisted of 240 Kashmiri individuals. Of these, 100 individuals belonging to the high risk conditions were drawn from Kupwara and Budgam and the remaining 140 individuals were hailing from the low risk condition or place i.e. Srinagar. The relevance of taking sub-samples from the different areas is that high and low risk conditions will differentially influence the perception of traumatic stress and coping styles. The sample was further split in terms of the variable of gender, i.e. males and females.

The distribution of the sample is given below :



Tools Two tests for assessing the traumatic stress and coping styles were developed by the author by applying item analysis.

Item Analysis It is particularly relevant to the construction of psychological tests. Items can be analysed qualitatively in terms of their content and form, and quantitatively in terms of their statistical properties. Qualitative analysis includes the consideration of content validity as well as the evaluation of items in terms of effective item-writing procedures. Quantitative analysis includes principally the measurement of item difficulty and item discrimination. Both the validity and the reliability of any test depend ultimately on the characteristics of its items. High reliability and validity can be built into a test in advance through item analysis. Tests can be improved through the selection, substitution, or revision of items. Item analysis makes it possible to shorten a test and at the same time to increase its validity and reliability.

Traumatic Stress Inventory Quantitative analysis was used to develop Traumatic Stress Inventory (TSI) which includes the measurement of item difficulty and item discrimination.

Item Difficulty For most testing purposes, the difficulty of an item is defined in terms of the proportion (or percentage) of individuals who answer it correctly. The easier the item, the larger this percentage or porportion will be. Here the items are arranged in order of difficulty, so that test takers begin with relatively easy items to proceed to items of increasing difficulty. This arrangement gives the test takers confidence

in approaching the test and also reduces the likelihood of their wasting much time on items beyond their ability to the neglect of easier items they can correctly complete.

Item Discrimination It refers to the degree to which an item differentiates correctly among test takers in the behaviour that the test is designed to measure. For the Traumatic Stress Inventory (TSI), responses were recorded as 'Yes' or 'No'. The measurement of item discrimination usually involves a dichotomous variable (the item) and a continuous variable (the criterion).

A common practice in item analysis is to compare the proportion of cases that pass an item in contrasting criterion groups. The two extreme groups such as lower 27% and upper 73% were identified. The number of subjects endorsing each item in U and L criterion groups are expressed in proportions, the differences between these two proportions provide an index of discrimination (cf. Tables 1a & b). Any item whose ϕ reached or exceeded .17 were selected. The criterion set for the item selection was at the .05 and .01 levels of significance. Thus, all the 30 items were retained.

The split-half reliability for the TSI was found to be 0.92.

Table 1(a) - Simple item analysis procedure : Number of persons giving correct response in each criterion group

Item	U	M	L	Difficult (U+M+L)	Discrimination (U-L)
1	5	4	0	9	5
2	25	17	1	43	24
3	29	52	18	99	11
4	19	23	9	51	10
5	26	32	5	63	21
6	18	33	9	60	9
7	20	19	1	40	19
8	45	45	4	93	41
9	51	66	12	129	39
10	19	12	1	32	18
11	6	0	0	6	6
12	29	20	1	50	28
13	26	8	3	37	23
14	23	16	2	41	21
15	51	82	27	160	25
16	21	12	3	36	18
17	47	55	13	115	34
18	58	88	22	168	36
19	33	18	2	53	31
20	29	28	7	64	22
21	49	46	3	98	46
22	23	15	1	39	22
23	29	14	6	49	23
24	47	42	4	95	43
25	33	33	2	68	31
26	43	31	0	74	43
27	26	21	0	47	26
28	52	67	7	126	45
29	53	72	6	131	47
30	51	43	3	97	48

Table 1(b) - Computation of Index of Discrimination of Traumatic Stress Inventory.

Item	Proportion Passing		Index of Discrimination	ϕ
	Upper Group	Lower Group		
1	.079	0	.079	.281
2	.396	.015	.381	.471
3	.460	.272	.188	.425
4	.301	.136	.165	.199
5	.412	.075	.337	.392
6	.285	.136	.149	.182
7	.317	.015	.302	.403
8	.714	.060	.654	.689
9	.809	.181	.628	.628
10	.301	.015	.286	.392
11	.095	0	.095	.294
12	.460	.015	.445	.522
13	.412	.045	.367	.437
14	.365	.030	.335	.528
15	.809	.409	.4	.409
16	.333	.045	.288	.367
17	.746	.196	.55	.550
18	.920	.333	.587	.606
19	.523	.030	.493	.551
20	.460	.106	.354	.392
21	.777	.045	.732	.743
22	.365	.015	.35	.446
23	.460	.090	.37	.414
24	.746	.060	.686	.703
25	.523	.030	.493	.551
26	.682	0	.682	-.719
27	.412	0	.412	.509
28	.825	.106	.719	.720
29	.841	.090	.751	.752
30	.809	.045	.764	.772

Coping Styles Inventory Item analysis method was also used to develop the Coping Styles Inventory (CSI). The procedure described above for the development of TSI was also adopted here. The number of subjects endorsing each item in U and L criterion groups, are expressed in terms of proportions, the difference between the proportions of upper group and lower group provide an index of discrimination.

Items whose ϕ was equal to or exceeded .174 were selected. The criterion set for the item selection was at the .01 level of significance. Thus, 40 items were retained in the inventory.

The split-half reliability of the CSI was found to be 0.87.

Table 2(a) - Simple item analysis procedure : Number of persons giving correct response in each criterion group.

Item	U	M	L	Difficult (U+M+L)	Discrimination (U-L)
1	57	79	28	164	29
2	20	30	8	58	12
3	46	70	31	147	15
4	41	62	12	115	29
5	12	15	6	33	6
6	53	96	44	193	9
7	50	66	31	147	19
8	23	25	9	57	14
9	37	53	25	115	12
10	47	54	16	117	31
11	33	52	14	99	19
12	52	87	31	170	21
13	39	50	18	107	21

14	42	41	20	103	22
15	37	64	11	112	26
16	27	21	3	51	24
17	48	89	29	166	19
18	46	68	23	137	23
19	6	6	3	15	3*
20	48	47	12	107	36
21	35	48	6	89	29
22	18	38	6	62	12
23	42	52	.17	111	25
24	29	35	5	69	24
25	37	46	7	90	30
26	57	51	24	132	33
27	16	14	5	35	11
28	16	17	3	36	13
29	45	63	13	121	32
30	35	26	11	72	24
31	15	15	5	35	10
32	27	29	5	61	22
33	40	52	10	82	30
34	9	5	3	17	6
35	46	63	24	133	22
36	28	21	3	52	25
37	26	29	7	62	19
38	20	10	2	32	18
39	26	19	3	48	23
40	34	51	11	96	23
41	33	26	16	75	17
42	7	2	2	11	5*

Table 2(b) - Computation of Index of Discrimination of Coping Styles Inventory.

Item	Proportion Passing		Index of Discrimination	ϕ
	Upper Group	Lower Group		
1	.982	.411	.571	.620
2	.344	.117	.227	.269
3	.793	.455	.338	.348
4	.706	.176	.53	.533
5	.206	.088	.118	.233
6	.913	.64	.273	.327
7	.862	.455	.407	.429
8	.396	.132	.264	.299
9	.637	.367	.27	.270
10	.810	.235	.575	.575
11	.568	.205	.363	.389
12	.897	.455	.441	.468
13	.672	.264	.408	.408
14	.724	.294	.43	.430
15	.637	.161	.476	.486
16	.465	.044	.421	.483
17	.827	.426	.401	.414
18	.793	.338	.455	.458
19	.103	.044	.099	.113*
20	.827	.176	.651	.651
21	.603	.088	.515	.541
22	.310	.088	.222	.278
23	.724	.25	.474	.474
24	.5	.073	.427	.472
25	.637	.102	.535	.554

26	.982	.352	.63	.668
27	.275	.073	.202	.266
28	.275	.044	.231	.326
29	.775	.191	.584	.584
30	.603	.161	.442	.454
31	.258	.073	.185	.248
32	.465	.073	.392	.442
33	.689	.147	.542	.549
34	.155	.044	.111	.185
35	.793	.352	.441	.450
36	.482	.044	.438	.497
37	.448	.102	.346	.387
38	.344	.029	.315	.404
39	.448	.044	.404	.469
40	.586	.161	.425	.439
41	.568	.025	.543	.594
42	.120	.029	.091	.173

Personal Data Sheet It includes information about subjects' sex, occupational status, and area of living (i.e. high or low risk conditions).

Procedure The data were collected individually from the subjects through face-to-face interview method. Prior to data collection, the investigator established rapport with the subjects. Each subject was assured that his/her responses would be kept strictly confidential and will be used for research purpose only. Subjects generally took 30 minutes time in completing the inventories.

Data Analysis The data were analyzed by means of certain appropriate statistical tests such as item analysis and critical ratio of percentages. Item analysis method was used to develop the tools, namely, traumatic stress inventory and coping styles inventory. Data were converted into percentage to analyse. It helped in understanding what percent of the sample face a particular category of traumatic stress and what percentage of the sample use a particular coping style to cope with traumatic stress. Percentages helped in doing analysis gender wise and area wise i.e. high and low risk conditions. Critical Ratio was used to examine the differences between percentages in comparison groups on traumatic stress and coping styles inventories.

Chapter Four

RESULTS AND DISCUSSION

The analysis were done area of living-wise that is, comparison between people of Kashmir living in high and low risk conditions, and gender-wise comparison (Male Vs Female). The data analysed by means of critical ratio of percentages (CR) are presented in the following tables - 3 to 12.

Table 3 - Indicating differences between the percentages of individuals living in High Risk Conditions (HRC) and Low Risk Conditions (LRC) on the following traumatic stressors.

Item 1 : Threat of firing

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	29.00					
			51.24	48.76	6.51	-5.85	< .01
LRC	140	67.14					

Item 2 : Fear of crackdown or searching operations.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	30.00					
			47.91	52.09	6.51	-4.71	< .01
LRC	140	60.71					

Item 3 : Panic

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	60.00					
			36.24	63.76	6.26	1.48	> .05
LRC	140	50.71					

Item 4 : Threat of war/violence.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	54.00					
			53.74	46.26	6.5	-0.06	> .05
LRC	140	67.14					

Item 5 : Anger, hostility and aggressive behaviour of administration.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	63.00					
			52.5	47.5	6.51	2.76	< .01
LRC	140	45.00					

Item 6 : Bomb blast near my house.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	42.00					
			47.91	52.09	6.51	-1.55	> .05
LRC	140	52.14					

Item 7 : Death of a close family member.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	39.00					
			41.24	58.76	6.41	-0.60	> .05
LRC	140	42.85					

Item 8 : Threat of life.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	50.00					
			40.83	59.17	6.40	2.45	<.05
LRC	140	34.28					

Item 9 : Survived by chance.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	40.00					
			40.40	59.60	6.39	-0.11	7.05
LRC	140	40.71					

Item 10 : Survival by freak circumstances.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	41.00					
			39.58	60.42	6.37	0.38	> .05
LRC	140	38.57					

Item 11 : Financial losses.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	37.00					
			38.75	61.25	6.35	-0.47	> .05
LRC	140	40.00					

Item 12 : Tension caused by resistance and ignoring the warning to cooperate/to obey.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	33.00					
			36.74	63.26	6.28	-0.88	> .05
LRC	140	38.57					

Item 13 : Migration to safer places and displacement.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	28.00					
			28.33	71.67	5.87	-0.09	> .05
LRC	140	28.57					

Item 14 : Troublesome neighbours.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	23.00					
			26.66	73.34	5.7	-1.10	> .05
LRC	140	29.28					

Item 15 : Major personal illness or injury.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	27.00					
			26.24	73.76	5.73	0.34	> .05
LRC	140	25.00					

Item 16 : Self or family members become unemployed.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	28.00					
			24.99	75.01	5.64	0.913	> .05
LRC	140	22.85					

Item 17 : Enforced change of residence.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	23.00					
			22.06	77.94	5.4	0.29	> .05
LRC	140	21.40					

Item 18 : Robbery or theft in the house.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	18.00					
			21.24	78.76	5.33	-1.04	> .05
LRC	140	23.57					

Item 19 : Torture of a family member in the prison.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	20.00					
			20.82	79.18	5.29	-0.26	> .05
LRC	140	21.42					

Item 20 : Seeing death of military jawans.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	19.00					
			20.40	79.60	5.25	-0.45	> .05
LRC	140	21.40					

Item 21 : Separation reactions of young children.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	23.00					
			19.58	80.42	5.17	1.13	> .05
LRC	140	17.14					

Item 22 : Detention in jail of a close family member.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	16.00					
			17.80	82.20	4.98	-0.642	> .05
LRC	140	19.20					

Item 23 : Unexpected death of a close family member during encounter.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	26.00					
			18.74	81.26	5.08	2.44	< .05
LRC	140	13.57					

Item 24 : Disintegration/breaking of the family.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	32.00					
			22.08	77.92	5.4	3.14	< .01
LRC	140	15.00					

Item 25 : Dissociation from the family member.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	17.00					
			16.25	83.75	4.8	0.26	> .05
LRC	140	15.71					

Item 26 : Robbery of expensive valuables during search operations.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
HRC	100	16.00					
			16.66	83.34	4.8	-0.23	> .05
LRC	140	17.14					

Item 27 : Demands after abduction of a family member.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
HRC	100	18.00					
			14.99	85.01	4.65	1.10	> .05
LRC	140	12.85					

Item 28 : Abduction.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
HRC	100	12.00					
			11.24	88.76	4.11	0.31	> .05
LRC	140	10.7					

Item 29 : Detention in jail of oneself.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
HRC	100	6.00					
			3.74	96.26	2.47	156	> .05
LRC	140	2.14					

Item 30 : Sexual assault and rape.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
HRC	100	0.00					
			0.01	99.99	0.130	-27.46	<.01
LRC	140	3.57					

Table 4 - Indicating differences between the percentages of Males Living in High Risk Conditions (MLHRC) and Females living in High Risk Conditions (FLHRC) on the following traumatic stressors.

Item 1 : Threat of firing.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	73.52					
			73.99	26.01	9.30	-0.15	> .05
FLHRC	32	75.00					

Item 2 : Fear of crackdown or searching operations.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	73.52					
			74.44	25.01	9.18	-0.50	> .05
FLHRC	32	78.12					

Item 3 : Panic.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	60.29					
			59.99	40.01	10.39	0.08	> .05
FLHRC	32	59.37					

Item 4 : Threat of war/violence.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	51.47					
			53.99	46.01	10.57	-0.74	> .05
FLHRC	32	59.37					

Item 5 : Anger, hostility and aggressive behaviour of administration.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	58.82					
			62.99	37.01	10.24	-1.24	> .05
FLHRC	32	71.87					

Item 6 : Bomb blast near my house.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	39.70					
			41.99	58.01	10.46	-0.68	> .05
FLHRC	32	46.87					

Item 7 : Death of a close family member.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	38.23					
			38.99	61.01	10.3	0.23	> .05
FLHRC	32	40.62					

Item 8 : Threat of life.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	47.05					
			49.99	50.01	10.60	-0.86	> .05
FLHRC	32	56.25					

Item 9 : Survived by chance.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	45.58					
			39.99	60.01	10.39	1.68	> .05
FLHRC	32	28.12					

Item 10 : Survival by freak circumstances.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	42.64					
			40.99	59.01	10.43	0.49	> .05
FLHRC	32	37.5					

Item 11 : Financial losses.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	41.17					
			36.99	63.01	10.24	1.27	> .05
FLHRC	32	28.12					

Item 12 : Tension caused by resistance and ignoring the warning to cooperate/to obey.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	38.23					
			32.99	67.01	9.97	1.64	> .05
FLHRC	32	21.87					

Item 13 : Migration to safer places and displacement.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	23.52					
			27.99	72.01	9.52	-1.46	> .05
FLHRC	32	37.5					

Item 14 : Troublesome neighbours.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	20.58					
			22.99	77.01	8.92	-0.84	> .05
FLHRC	32	28.12					

Item 15 : Major personal illness or injury.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	23.52					
			26.99	73.01	9.416	-1.15	> .05
FLHRC	32	34.37					

Item 16 : Self or family members become unemployed.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	27.94					
			27.99	72.01	9.52	-0.01	> .05
FLHRC	32	28.12					

Item 17 : Enforced change of residence.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	22.05					
			22.99	77.01	8.92	-0.33	> .05
FLHRC	32	25.00					

Item 18 : Robbery or theft in the house.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	19.11					
			17.99	82.01	8.14	0.42	> .05
FLHRC	32	15.62					

Item 19 : Torture of a family member in the prison.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	23.52					
			19.99	80.01	8.4	1.31	> .05
FLHRC	32	12.5					

Item 20 : Seeing death of military jawans.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	16.17					
			18.99	81.01	8.32	-1.06	> .05
FLHRC	32	25.00					

Item 21 : Separation reactions of young children.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	23.52					
			22.99	77.01	8.92	0.18	> .05
FLHRC	32	21.87					

Item 22 : Detention in jail of a close family member.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	14.70					
			15.99	84.01	7.7	-0.52	> .05
FLHRC	32	18.75					

Item 23 : Unexpected death of a close family member during encounter.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	23.52					
			25.99	74.01	9.30	-0.83	> .05
FLHRC	32	31.25					

Item 24 : Disintegration/breaking of the family.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	19.11					
			31.99	68.01	9.89	-4.06	< .01
FLHRC	32	59.35					

Item 25 : Dissociation from the family member.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	16.17					
			16.99	83.01	7.96	-0.32	> .05
FLHRC	32	18.75					

Item 26 : Robbery of expensive valuables during search operations.

Subjects	N	%	P	Q	σD%	CR	p
MLHRC	68	19.11					
			14.99	85.01	7.57	1.69	> .05
FLHRC	32	6.25					

Item 27 : Demands after abduction of a family member.

Subjects	N	%	P	Q	σD%	CR	p
MLHRC	68	17.64					
			17.99	82.01	8.14	-0.13	> .05
FLHRC	32	18.75					

Item 28 : Abduction.

Subjects	N	%	P	Q	σD%	CR	p
MLHRC	68	10.29					
			11.99	88.01	6.89	-0.77	> .05
FLHRC	32	1562					

Item 29 : Detention in jail of oneself.

Subjects	N	%	P	Q	σD%	CR	p
MLHRC	68	7.35					
			5.99	94.01	5.03	0.84	> .05
FLHRC	32	3.12					

Item 30 : Sexual assault and rape.

Subjects	N	%	P	Q	σD%	CR	p
MLHRC	68	0					
			0	0	0	0	> .05
FLHRC	32	0					

Table 5 - Indicating differences between the percentages of Males Living in Low Risk Conditions (MLLRC) and Females Living in Low Risk Conditions (FLLRC) on the following traumatic stressors.

Item 1 : Threat of firing.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	71.92					
			67.13	32.87	7.99	1.01	> .05
FLLRC	32	63.85					

Item 2 : Fear of crackdown or searching operations.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	59.64					
			60.70	39.30	8.31	-0.21	> .05
FLLRC	32	61.44					

Item 3 : Panic.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	57.89					
			50.71	49.29	8.51	1.40	> .05
FLLRC	32	45.78					

Item 4 : Threat of war/violence.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	56.14					
			53.56	46.44	8.49	0.51	> .05
FLLRC	32	51.80					

Item 5 : Anger, hostility and aggressive behaviour of administration.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	59.64					
			44.99	55.01	8.47	2.90	< .01
FLLRC	32	34.93					

Item 6 : Bomb blast near my house.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	63.15					
			52.13	47.87	8.50	2.18	< .05
FLLRC	32	44.57					

Item 7 : Death of a close family member.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	36.84					
			42.85	57.15	8.42	-1.20	> .05
FLLRC	32	46.98					

Item 8 : Threat of life.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	49.12					
			34.28	65.72	8.08	3.09	< .01
FLLRC	32	24.09					

Item 9 : Survived by chance.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	52.63					
			40.71	59.28	8.36	2.40	< .01
FLLRC	32	32.53					

Item 10 : Survival by freak circumstances.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	42.10					
			38.56	61.44	8.20	0.72	> .05
FLLRC	32	36.14					

Item 11 : Financial losses.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	45.6					
			39.99	60.01	8.34	1.13	> .05
FLLRC	32	36.14					

Item 12 : Tension caused by resistance and ignoring the warning to cooperate/to obey.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	42.10					
			38.56	61.44	8.28	0.71	> .05
FLLRC	32	36.14					

Item 13 : Migration to safer places and displacement.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	36.84					
			28.56	71.44	7.69	1.81	> .05
FLLRC	83	22.89					

Item 14 : Troublesome neighbours.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	29.82					
			29.28	70.72	7.74	0.11	> .05
FLLRC	32	28.91					

Item 15 : Major personal illness or injury.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	31.57					
			25.67	74.33	7.43	1.33	> .05
FLLRC	32	21.68					

Item 16 : Self or family members become unemployed.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	26.31					
			22.85	77.15	7.15	0.81	> .05
FLLRC	32	20.48					

Item 17 : Enforced change of residence.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	28.07					
			21.42	78.58	6.98	1.60	> .05
FLLRC	32	16.86					

Item 18 : Robbery or theft in the house.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	28.07					
			23.57	76.43	7.22	1.05	> .05
FLLRC	32	20.48					

Item 19 : Torture of a family member in the prison.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	31.51					
			21.42	78.58	6.98	2.45	< .05
FLLRC	32	14.45					

Item 20 : Seeing death of military jawans.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	28.07					
			21.42	78.58	6.98	1.60	> .05
FLLRC	32	16.86					

Item 21 : Separation reactions of young children.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	24.56					
			17.13	82.87	6.41	1.95	> .05
FLLRC	32	12.04					

Item 22 : Detention in jail of a close family member.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	28.07					
			19.28	80.72	6.71	2.20	< .05
FLLRC	32	13.25					

Item 23 : Unexpected death of a close family member during encounter.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	17.54					
			13.56	86.44	5.83	1.14	> .05
FLLRC	32	10.84					

Item 24 : Disintegration/breaking of the family.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	17.54					
			14.99	85.01	6.07	0.70	> .05
FLLRC	32	13.25					

Item 25 : Dissociation from the family member.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	24.56					
			15.68	84.32	6.19	2.40	< .05
FLLRC	32	9.63					

Item 26 : Robbery of expensive valuables during search operations.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	22.80					
			17.13	82.87	6.41	1.48	> .05
FLLRC	32	13.25					

Item 27 : Demands after abduction of a family member.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	10.52					
			12.84	87.16	5.6	-0.70	> .05
FLLRC	32	14.45					

Item 28 : Abduction.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	19.29					
			14.28	85.72	5.95	1.42	> .05
FLLRC	32	10.84					

Item 29 : Detention in jail of oneself.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	5.26					
			2.14	97.86	2.46	2.13	< .05
FLLRC	32	0.00					

Item 30 : Sexual assault and rape.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	5.26					
			3.56	96.44	3.15	0.90	> .05
FLLRC	32	2.40					

Table 6 - Indicating differences between the percentages of Males Living in High Risk Conditions (MLHRC) and Males Living in Low Risk Conditions (MLLRC) on the following traumatic stressors.

Item 1 : Threat of firing.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	73.52					
			72.79	27.21	7.83	0.20	> .05
MLLRC	57	71.92					

Item 2 : Fear of crackdown or searching operations.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	73.52					
			67.19	32.81	8.26	1.68	> .05
MLLRC	57	59.64					

Item 3 : Panic.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	60.29					
			59.19	40.81	8.65	0.27	> .05
MLLRC	57	57.89					

Item 4 : Threat of war/violence.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	51.47					
			53.59	46.41	8.78	-0.53	> .05
MLLRC	57	56.14					

Item 5 : Anger, hostility and aggressive behaviour of administration.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	58.82					
			59.19	40.81	8.65	-0.09	> .05
MLLRC	57	59.64					

Item 6 : Bomb blast near my house.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	39.70					
			48.80	51.20	8.80	2.66	< .01
MLLRC	57	63.15					

Item 7 : Death of a close family member.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	38.23					
			37.59	62.41	8.52	0.16	> .05
MLLRC	57	36.84					

Item 8 : Threat of life.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	47.05					
			47.99	52.01	8.79	-0.23	> .05
MLLRC	57	49.12					

Item 9 : Survived by chance.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	45.58					
			37.42	62.58	8.52	-0.82	> .05
MLLRC	57	52.63					

Item 10 : Survival by freak circumstances.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	42.64					
			42.39	57.61	8.70	0.06	> .05
MLLRC	57	42.10					

Item 11 : Financial losses.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	41.17					
			43.19	56.81	8.72	-0.50	> .05
MLLRC	57	45.61					

Item 12 : Tension caused by resistance and ignoring the warning to cooperate/to obey.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	38.23					
			39.99	60.01	8.62	-0.44	> .05
MLLRC	57	42.10					

Item 13 : Migration to safer places and displacement.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	23.52					
			29.59	70.41	8.03	-1.65	> .05
MLLRC	57	36.84					

Item 14 : Troublesome neighbours.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	20.58					
			24.79	75.21	7.60	-1.21	> .05
MLLRC	57	29.83					

Item 15 : Major personal illness or injury.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	23.52					
			27.19	72.81	7.83	-1.02	> .05
MLLRC	57	31.57					

Item 16 : Self or family members become unemployed.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	27.94					
			18.35	82.65	6.81	0.23	> .05
MLLRC	57	26.31					

Item 17 : Enforced change of residence.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	22.05					
			24.79	75.21	7.60	-0.79	> .05
MLLRC	57	28.07					

Item 18 : Robbery or theft in the house.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	19.11					
			23.19	76.81	7.43	-1.20	> .05
MLLRC	57	28.07					

Item 19 : Torture of a family member in the prison.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	23.52					
			27.19	72.81	7.83	-1.02	> .05
MLLRC	57	31.57					

Item 20 : Seeing death of military jawans.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	16.17					
			21.59	78.41	7.24	-1.64	> .05
MLLRC	57	28.07					

Item 21 : Separation reactions of young children.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	23.52					
			23.99	76.01	7.51	-0.13	> .05
MLLRC	57	24.56					

Item 22 : Detention in jail of a close family member.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	14.70					
			20.79	79.21	7.14	-1.87	> .05
MLLRC	57	28.07					

Item 23 : Unexpected death of a close family member during encounter.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	23.52					
			20.79	79.21	7.14	0.83	> .05
MLLRC	57	17.54					

Item 24 : Disintegration/breaking of the family.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	19.11					
			18.39	81.61	6.82	0.23	> .05
MLLRC	57	17.54					

Item 25 : Dissociation from the family member.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	16.17					
			19.99	80.01	7.04	-1.19	> .05
MLLRC	57	24.56					

Item 26 : Robbery of expensive valuables during search operations.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	19.11					
			20.79	79.21	7.14	0.51	> .05
MLLRC	57	22.80					

Item 27 : Demands after abduction of a family member.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	17.64					
			14.39	85.61	6.17	1.15	> .05
MLLRC	57	10.52					

Item 28 : Abduction.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	10.29					
			14.39	85.61	6.17	-1.45	> .05
MLLRC	57	19.29					

Item 29 : Detention in jail of oneself.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	7.35					
			6.39	93.61	4.30	0.48	> .05
MLLRC	57	5.26					

Item 30 : Sexual assault and rape.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	0.00					
			2.39	97.60	2.68	-1.96	> .05
MLLRC	57	5.26					

Table 7 - Indicating differences between the percentages of Females Living in High Risk Conditions (FLHRC) and Females Living in Low Risk Conditions (FLLRC) on the following traumatic stressors.

Item 1 : Threat of firing.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	75.00					
			66.95	33.05	9.75	1.14	> .05
FLLRC	83	63.85					

Item 2 : Fear of crackdown or searching operations.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	78.12					
			66.08	33.92	9.817	1.69	> .05
FLLRC	83	61.44					

Item 3 : Panic.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	59.37					
			49.56	50.44	10.36	1.31	> .05
FLLRC	83	45.78					

Item 4 : Threat of war/violence.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	59.37					
			53.90	46.10	10.33	0.73	> .05
FLLRC	83	51.80					

Item 5 : Anger, hostility and aggressive behaviour of administration.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	71.87					
			45.20	54.80	10.32	3.57	< .01
FLLRC	83	34.93					

Item 6 : Bomb blast near my house.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	46.87					
			45.21	54.79	10.32	0.22	> .05
FLLRC	83	44.57					

Item 7 : Death of a close family member.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	40.62					
			45.21	54.79	10.32	-0.61	> .05
FLLRC	83	46.98					

Item 8 : Threat of life.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	56.25					
			33.03	66.97	9.75	3.29	< .01
FLLRC	83	24.09					

Item 9 : Survived by chance.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	28.12					
			31.30	68.69	9.615	-0.45	> .05
FLLRC	83	32.53					

Item 10 : Survival by freak circumstances.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	37.5					
			36.51	63.49	9.98	0.13	> .05
FLLRC	83	36.14					

Item 11 : Financial losses.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	28.12					
			33.90	66.10	9.81	-0.81	> .05
FLLRC	83	36.14					

Item 12 : Tension caused by resistance and ignoring the warning to cooperate/to obey.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	21.87					
			32.16	67.84	9.68	1.47	> .05
FLLRC	83	36.14					

Item 13 : Migration to safer places and displacement.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	37.5					
			26.95	73.05	9.20	1.58	> .05
FLLRC	83	22.89					

Item 14 : Troublesome neighbours.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	28.12					
			28.69	71.31	9.37	-0.08	> .05
FLLRC	83	28.91					

Item 15 : Major personal illness or injury.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	34.37					
			25.21	74.78	9.00	1.41	> .05
FLLRC	83	21.68					

Item 16 : Self or family members become unemployed.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	28.12					
			22.60	77.40	8.67	0.88	> .05
FLLRC	83	20.48					

Item 17 : Enforced change of residence.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	25.00					
			19.12	80.87	8.15	0.99	> .05
FLLRC	83	16.86					

Item 18 : Robbery or theft in the house.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	15.62					
			19.12	80.88	8.15	-0.59	> .05
FLLRC	83	20.48					

Item 19 : Torture of a family member in the prison.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	12.5					
			13.90	86.10	7.17	-0.27	> .05
FLLRC	83	14.45					

Item 20 : Seeing death of military jawans.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	25.0					
			19.12	80.87	8.15	0.99	> .05
FLLRC	83	16.86					

Item 21 : Separation reactions of young children.

Subjects	N	%	P	Q	$^{c}D\%$	CR	p
FLHRC	32	21.87					
			14.78	85.22	7.35	1.33	> .05
FLLRC	83	12.04					

Item 22 : Detention in jail of a close family member.

Subjects	N	%	P	Q	$^{c}D\%$	CR	p
FLHRC	32	18.75					
			14.78	85.22	7.35	0.74	> .05
FLLRC	83	13.25					

Item 23 : Unexpected death of a close family member during encounter.

Subjects	N	%	P	Q	$^{c}D\%$	CR	p
FLHRC	32	31.25					
			16.51	83.49	7.69	2.65	< .01
FLLRC	83	10.84					

Item 24 : Disintegration/breaking of the family.

Subjects	N	%	P	Q	$^{c}D\%$	CR	p
FLHRC	32	59.35					
			26.08	73.92	9.10	5.06	< .01
FLLRC	83	13.25					

Item 25 : Dissociation from the family member.

Subjects	N	%	P	Q	$^{c}D\%$	CR	p
FLHRC	32	18.75					
			12.167	87.83	6.77	1.34	> .05
FLLRC	83	9.63					

Item 26 : Robbery of expensive valuables during search operations.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	6.25					
			11.30	88.70	6.56	-1.06	> .05
FLLRC	83	13.25					

Item 27 : Demands after abduction of a family member.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	18.75					
			15.64	84.36	7.53	0.57	> .05
FLLRC	83	14.45					

Item 28 : Abduction.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	15.62					
			12.17	87.83	6.77	0.70	> .05
FLLRC	83	10.84					

Item 29 : Detention in jail of oneself.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	3.12					
			0.27	99.73	1.07	2.91	< .01
FLLRC	83	0.00					

Item 30 : Sexual assault and rape.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	0.00					
			1.73	98.27	2.70	0.88	> .05
FLLRC	83	2.40					

Table 8 - Indicating differences between the percentages of individuals Living in High and Low Risk Conditions on the following coping styles.

Item 1 : I often think that help would come from God.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	77.00					
			80.38	19.62	5.17	-1.13	> .05
LRC	140	82.85					

Item 2 : I often think about the positive aspects of the situation.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	70.00					
			70.41	29.59	5.95	-0.11	> .05
LRC	140	70.71					

Item 3 : I have found that only putting faith in God can change the circumstances.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	65.00					
			69.16	30.84	6.02	1.18	> .05
LRC	140	72.14					

Item 4 : I learn new skills to tackle the problem more effectively.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	61.00					
			67.91	32.09	6.00	-1.97	> .05
LRC	140	72.85					

Item 5 : I try to figure out who is to be blamed for the situation.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	57.00					
			60.41	39.59	6.37	-0.91	> .05
LRC	140	62.85					

Item 6 : I plan a strategy to deal with the problem effectively.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	59.00					
			61.24	38.76	6.35	-0.60	> .05
LRC	140	62.85					

Item 7 : I have been trying to cope with the situation through prayers and spiritual beliefs.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	53.00					
			57.00	43.00	6.45	-1.08	> .05
LRC	140	60.00					

Item 8 : I engage in some creative activities like writing, reading, drawing etc.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	66.00					
			59.16	40.84	6.40	1.83	> .05
LRC	140	54.28					

Item 9 : I spend time alone and think about the situation.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	55.00					
			58.33	41.67	6.42	-0.88	> .01
LRC	140	60.71					

Item 10 : I discuss with other people and try to work out a plan to make the situation better.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	49.00					
			49.16	50.84	6.51	-0.04	> .05
LRC	140	49.28					

Item 11 : I seek emotional support from others in solving the problem.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
HRC	100	46.00					
			48.74	51.26	6.50	0.72	> .05
LRC	140	50.71					

Item 12 : I avoid the things that have caused the problem.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
HRC	100	41.00					
			47.49	52.51	6.51	-1.71	> .05
LRC	140	52.14					

Item 13 : I become irritable and blame the government and others for the situation.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
HRC	100	51.00					
			47.91	52.09	6.50	0.81	> .05
LRC	140	45.71					

Item 14 : I have been trying to forget the trouble.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
HRC	100	48.00					
			48.74	51.26	6.51	-0.19	> .05
LRC	140	49.28					

Item 15 : I engage in watching T.V.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
HRC	100	33.00					
			46.24	53.76	6.50	-3.49	< .01
LRC	140	55.71					

Item 16 : I engage myself in seeking social support from family members.

Subjects	N	%	P	Q	σD%	CR	p
HRC	100	46.00					
			44.58	55.42	6.48	0.37	> .05
LRC	140	43.57					

Item 17 : I engage myself in meditation or relaxation exercise to overcome the problem.

Subjects	N	%	P	Q	σD%	CR	p
HRC	100	46.00					
			44.58	55.42	6.4	0.37	> .05
LRC	140	43.57					

Item 18 : I take some direct action to change the circumstances that have caused the problem.

Subjects	N	%	P	Q	σD%	CR	p
HRC	100	36.00					
			42.49	57.51	6.44	-1.72	> .05
LRC	140	47.14					

Item 19 : I accept the situation as unavoidable.

Subjects	N	%	P	Q	σD%	CR	p
HRC	100	37.00					
			40.83	59.17	6.4	-1.02	> .05
LRC	140	43.57					

Item 20 : I go for a walk or short trips.

Subjects	N	%	P	Q	σD%	CR	p
HRC	100	52.00					
			43.33	56.67	6.46	2.30	< .05
LRC	140	37.14					

Item 21 : I take my mind away from the problem by engaging in humour talk.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	33.00					
			38.33	61.67	6.33	-1.44	> .05
LRC	140	42.14					

Item 22 : I engage myself in some other activities like dancing or listening to music.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	30.00					
			37.49	62.51	6.31	-2.03	< .05
LRC	140	42.85					

Item 23 : I prefer to sleep.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	32.00					
			34.16	65.84	6.18	-0.60	> .05
LRC	140	35.71					

Item 24 : I prefer to live alone and engage in self-talking.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	35.00					
			35.82	64.18	6.25	-0.22	> .05
LRC	140	36.42					

Item 25 : I cut down my other responsibilities when the threatening situation arises.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	32.00					
			29.57	70.43	5.95	0.69	> .05
LRC	140	27.85					

Item 26 : I drink more tea, Kahwa or coffee.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	23.00					
			29.16	70.84	5.92	-1.78	> .05
LRC	140	33.57					

Item 27 : I cry.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	19.00					
			25.40	74.60	5.60	1.96	> .05
LRC	140	30.00					

Item 28 : I feel like fighting.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	27.00					
			25.83	74.17	5.70	0.35	> .05
LRC	140	25.00					

Item 29 : I divert my attention from discussion about the situation.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	28.00					
			26.25	73.75	5.73	0.52	> .05
LRC	140	25.00					

Item 30 : I put the problem out of my mind and refuse to think about it.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	21.00					
			24.16	75.84	5.58	-0.97	> .05
LRC	140	26.42					

Item 31 : I withdraw from situations and make no attempt to cope with the problem.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	15.00					
			14.16	85.84	4.54	0.31	> .05
LRC	140	13.57					

Item 32 : I imitate the action of others who have had the same experience.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	29.00					
			22.91	77.09	5.47	1.90	> .05
LRC	140	18.57					

Item 33 : I blame myself and feel guilty about the situation which has happened.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	25.00					
			21.44	78.56	5.35	1.20	> .05
LRC	140	18.57					

Item 34 : I daydream and fantasize.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	18.00					
			21.66	78.34	5.30	-1.18	> .05
LRC	140	24.28					

Item 35 : I skip meals.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	20.00					
			20.00	80.00	5.21	0.00	> .05
LRC	140	20.00					

Item 36: I go to places where there are lots of people like clubs or marriage parties.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	11.00					
			14.99	85.01	4.65	-1.43	> .05
LRC	140	17.85					

Item 37 : I prefer not to make any attempt to deal with it.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	17.00					
			14.57	85.43	4.60	0.90	> .05
LRC	140	12.85					

Item 38 : I smoke cigarettes or tobacco.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	20.00					
			14.58	85.42	4.60	2.01	< .05
LRC	140	10.71					

Item 39 : I feel like putting an end to my life.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	16.00					
			13.22	86.68	4.413	1.03	> .05
LRC	140	11.42					

Item 40 : I take tranquilizers.

Subjects	N	%	P	Q	°D%	CR	p
HRC	100	9.00					
			7.08	92.92	3.34	0.98	> .05
LRC	140	5.71					

Table 9 - Indicating differences between the percentages of Males Living in High Risk Conditions (MLHRC) and Females Living in High Risk Conditions (FLHRC) on the following coping styles.

Item 1 : I often think that help would come from God.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	73.50					
			77.29	22.71	8.88	-1.22	> .05
FLHRC	32	84.37					

Item 2 : I often think about the positive aspects of the situation.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	69.11					
			69.99	30.01	9.72	-0.32	> .05
FLHRC	32	71.87					

Item 3 : I have found that only putting faith in God can change the circumstances.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	61.76					
			64.99	35.01	10.11	-1.00	> .05
FLHRC	32	71.87					

Item 4 : I learn new skills to tackle the problem more effectively.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	64.70					
			60.99	39.01	10.34	1.11	> .05
FLHRC	32	53.12					

Item 5 : I try to figure out who is to be blamed for the situation.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	52.94					
			65.60	43.01	10.50	-1.20	> .05
FLHRC	32	52.94					

Item 6 : I plan a strategy to deal with the problem effectively.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	57.35					
			58.99	41.01	10.43	-0.49	> .05
FLHRC	32	62.50					

Item 7 : I have been trying to cope with the situation through prayers and spiritual beliefs.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	50.00					
			52.99	47.01	10.58	-0.88	> .05
FLHRC	32	59.37					

Item 8 : I engage in some creative activities like writing, reading, drawing etc.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	69.11					
			65.99	34.01	10.04	0.97	> .05
FLHRC	32	59.37					

Item 9 : I spend time alone and think about the situation.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	51.47					
			54.99	45.01	10.55	-1.04	> .05
FLHRC	32	62.50					

Item 10 : I discuss with other people and try to work out a plan to make the situation better.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	44.11					
			48.99	51.01	10.60	1.43	> .05
FLHRC	32	59.37					

Item 11 : I seek emotional support from others in solving the problem.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	42.64					
			45.99	54.01	10.57	-0.99	> .05
FLHRC	32	53.12					

Item 12 : I avoid the things that have caused the problem.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	41.1					
			40.94	59.06	10.43	.04	> .05
FLHRC	32	40.62					

Item 13 : I become irritable and blame the government and others for the situation.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	50.00					
			50.99	49.01	10.60	-0.29	> .05
FLHRC	32	53.12					

Item 14 : I have been trying to forget the trouble.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	48.52					
			47.99	52.01	10.59	0.15	> .05
FLHRC	32	46.87					

Item 15 : I engage in watching T.V.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	27.94					
			25.12	74.88	9.20	-1.71	> .05
FLHRC	32	43.75					

Item 16 : I engage myself in seeking social support from family members.

Subjects	N	%	P	Q	σD%	CR	p
MLHRC	68	42.64					
			45.99	54.01	10.57	-0.99	> .05
FLHRC	32	53.12					

Item 17 : I engage myself in meditation or relaxation exercise to overcome the problem.

Subjects	N	%	P	Q	σD%	CR	p
MLHRC	68	45.58					
			45.99	54.01	10.57	-0.12	> .05
FLHRC	32	46.87					

Item 18 : I take some direct action to change the circumstances that have caused the problem.

Subjects	N	%	P	Q	σD%	CR	p
MLHRC	68	36.76					
			35.99	64.01	10.18	.23	> .05
FLHRC	32	34.37					

Item 19 : I accept the situation as unavoidable.

Subjects	N	%	P	Q	σD%	CR	p
MLHRC	68	36.76					
			36.99	63.01	10.24	-0.07	> .05
FLHRC	32	37.5					

Item 20 : I go for a walk or short trips.

Subjects	N	%	P	Q	σD%	CR	p
MLHRC	68	58.82					
			51.99	48.01	10.59	2.01	< .05
FLHRC	32	37.50					

Item 21 : I take my mind away from the problem by engaging in humour talk.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	30.88					
			32.91	67.09	9.87	-0.66	> .05
FLHRC	32	37.50					

Item 22 : I engage myself in some other activities like dancing or listening to music.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	32.25					
			29.99	70.01	9.72	0.75	> .05
FLHRC	32	25.00					

Item 23 : I prefer to sleep.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	29.41					
			31.99	68.01	9.89	-0.81	> .05
FLHRC	32	37.5					

Item 24 : I prefer to live alone and engage in self-talking.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	30.88					
			34.99	65.01	10.11	-1.27	> .05
FLHRC	32	43.75					

Item 25 : I cut down my other responsibilities when the threatening situation arises.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	30.88					
			31.99	68.01	9.89	-0.35	> .05
FLHRC	32	34.37					

Item 26 : I drink more tea, Kahwa or coffee.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	23.52					
			22.99	77.01	8.92	0.18	> .05
FLHRC	32	21.87					

Item 27 : I cry.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	17.64					
			18.99	81.01	8.32	-0.50	> .05
FLHRC	32	21.87					

Item 28 : I feel like fighting.

Subjects	N	%	P	Q	D%	CR	p
MLHRC	68	25.00					
			27.00	73.00	9.41	-0.66	> .05
FLHRC	32	31.25					

Item 29 : I divert my attention from discussion about the situation.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	26.47					
			25.99	74.01	9.30	0.15	> .05
FLHRC	32	25					

Item 30 : I put the problem out of my mind and refuse to think about it.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	22.05					
			20.99	79.01	8.63	0.38	> .05
FLHRC	32	18.75					

Item 31 : I withdraw from situations and make no attempt to cope with the problem.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	14.70					
			14.99	85.01	7.5	-0.12	> .05
FLHRC	32	15.62					

Item 32 : I imitate the action of others who have had the same experience.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	35.29					
			28.98	71.02	9.62	2.04	< .05
FLHRC	32	15.62					

Item 33 : I blame myself and feel guilty about the situation which has happened.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	20.58					
			24.99	75.01	9.18	-1.50	> .05
FLHRC	32	34.37					

Item 34 : I daydream and fantasize.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	17.64					
			17.99	82.01	8.14	0.13	> .05
FLHRC	32	18.75					

Item 35 : I skip meals.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	14.70					
			19.99	80.01	8.48	-1.95	> .05
FLHRC	32	31.25					

Item 36: I go to places where there are lots of people like clubs or marriage parties.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	13.23					
			10.99	89.01	6.6	1.05	> .05
FLHRC	32	6.25					

Item 37 : I prefer not to make any attempt to deal with it.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	16.17					
			16.99	83.01	7.96	-0.32	> .05
FLHRC	32	18.75					

Item 38 : I smoke cigarettes or tobacco.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	22.05					
			19.99	80.01	8.48	0.75	> .05
FLHRC	32	15.62					

Item 39 : I feel like putting an end to my life.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	16.17					
			6.09	93.91	5.07	0.10	> .05
FLHRC	32	15.62					

Item 40 : I take tranquilizers.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	5.88					
			8.99	91.01	6.06	-1.60	> .05
FLHRC	32	15.62					

Table 10 -Indicating differences between the percentages of Males Living in Low Risk Conditions (MLLRC) and Females Living in Low Risk Conditions (FLLRC) on the following coping styles.

Item 1 : I often think that help would come from God.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	71.92					
			82.85	17.15	6.41	-2.87	< .01
FLLRC	83	90.36					

Item 2 : I often think about the positive aspects of the situation.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	61.40					
			70.70	29.30	7.75	-2.02	< .05
FLLRC	83	77.10					

Item 3 : I have found that only putting faith in God can change the circumstances.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	64.91					
			72.13	27.87	7.63	-1.59	> .05
FLLRC	83	77.10					

Item 4 : I learn new skills to tackle the problem more effectively.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	82.45					
			72.85	27.15	7.57	2.13	< .05
FLLRC	83	66.26					

Item 5 : I try to figure out who is to be blamed for the situation.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	63.15					
			62.85	37.15	8.22	0.06	>.05
FLLRC	83	62.65					

Item 6 : I plan a strategy to deal with the problem effectively.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
MLLRC	57	59.64					
			62.85	37.15	8.22	-0.65	>.05
FLLRC	83	65.06					

Item 7 : I have been trying to cope with the situation through prayers and spiritual beliefs.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
MLLRC	57	42.10					
			59.99	40.01	8.34	-3.61	< .01
FLLRC	83	72.28					

Item 8 : I engage in some creative activities like writing, reading, drawing etc.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
MLLRC	57	47.36					
			54.27	45.73	8.48	-1.37	>.05
FLLRC	83	59.03					

Item 9 : I spend time alone and think about the situation.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
MLLRC	57	57.89					
			60.71	39.29	8.3	-0.57	>.05
FLLRC	83	62.65					

Item 10 : I discuss with other people and try to work out a plan to make the situation better.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
MLLRC	57	50.87					
			49.28	50.72	8.5	0.31	>.05
FLLRC	83	48.19					

Item 11 : I seek emotional support from others in solving the problem.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	54.38					
			49.99	50.01	8.5	0.87	>.05
FLLRC	83	46.98					

Item 12 : I avoid the things that have caused the problem.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	45.61					
			52.13	47.87	8.50	-1.29	>.05
FLLRC	83	56.62					

Item 13 : I become irritable and blame the government and others for the situation.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	49.12					
			45.71	54.29	8.48	0.67	>.05
FLLRC	83	43.37					

Item 14 : I have been trying to forget the trouble.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	45.61					
			49.68	50.32	8.51	-0.72	>.05
FLLRC	83	51.80					

Item 15 : I engage in watching T.V.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	54.38					
			55.70	44.30	8.45	-0.26	>.05
FLLRC	83	56.62					

Item 16 : I engage myself in seeking social support from family members.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	36.84					
			43.56	56.44	8.44	-1.34	>.05
FLLRC	83	48.19					

Item 17 : I engage myself in meditation or relaxation exercise to overcome the problem.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	42.10					
			43.56	56.44	8.44	-0.29	>.05
FLLRC	83	44.57					

Item 18 : I take some direct action to change the circumstances that have caused the problem.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	49.12					
			47.13	52.87	8.5	0.39	>.05
FLLRC	83	45.78					

Item 19 : I accept the situation as unavoidable.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	43.85					
			43.56	56.44	8.44	0.05	>.05
FLLRC	83	43.37					

Item 20 : I go for a walk or short trips.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	49.12					
			37.13	62.87	8.22	2.45	<.05
FLLRC	83	28.91					

Item 21 : I take my mind away from the problem by engaging in humour talk.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	38.59					
			42.13	57.87	8.40	-0.71	>.05
FLLRC	83	44.57					

Item 22 : I engage myself in some other activities like dancing or listening to music.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	47.36					
			42.84	57.16	8.40	0.90	>.05
FLLRC	83	39.75					

Item 23 : I prefer to sleep.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	29.82					
			35.70	64.30	8.15	-1.21	>.05
FLLRC	83	39.75					

Item 24 : I prefer to live alone and engage in self-talking.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	26.31					
			36.42	63.58	8.19	-2.08	<.05
FLLRC	83	43.37					

Item 25 : I cut down my other responsibilities when the threatening situation arises.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	40.35					
			27.84	72.16	7.63	2.76	< .01
FLLRC	83	19.27					

Item 26 : I drink more tea, Kahwa or coffee.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	33.33					
			33.56	66.44	8.04	-0.04	> .05
FLLRC	83	33.73					

Item 27 : I cry.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	14.03					
			29.99	70.01	7.80	-3.45	< .01
FLLRC	83	40.96					

Item 28 : I feel like fighting.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	28.07					
			24.99	75.01	7.37	0.70	> .05
FLLRC	83	22.89					

Item 29 : I divert my attention from discussion about the situation.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	19.29					
			9.56	90.44	5.00	-1.92	> .05
FLLRC	83	28.91					

Item 30 : I put the problem out of my mind and refuse to think about it.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	19.29					
			26.42	73.58	7.50	-1.60	> .05
FLLRC	83	31.32					

Item 31 : I withdraw from situations and make no attempt to cope with the problem.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	19.29					
			13.56	86.44	5.83	1.65	> .05
FLLRC	83	9.63					

Item 32 : I imitate the action of others who have had the same experience.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	24.56					
			18.56	81.44	6.62	1.52	> .05
FLLRC	83	14.45					

Item 33 : I blame myself and feel guilty about the situation which has happened.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	10.52					
			18.5	81.5	6.612	-2.05	< .05
FLLRC	83	24.09					

Item 34 : I daydream and fantasize.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	26.31					
			24.2	75.8	7.29	0.46	> .05
FLLRC	83	22.89					

Item 35 : I skip meals.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	12.28					
			19.99	80.01	6.81	-1.91	> .05
FLLRC	83	25.30					

Item 36: I go to places where there are lots of people like clubs or marriage parties.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	21.05					
			17.85	82.15	6.52	0.82	> .05
FLLRC	83	15.66					

Item 37 : I prefer not to make any attempt to deal with it.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	10.52					
			12.84	87.16	5.69	-0.69	> .05
FLLRC	83	14.45					

Item 38 : I smoke cigarettes or tobacco.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	21.05					
			10.71	89.29	5.26	3.31	< .01
FLLRC	83	3.61					

Item 39 : I feel like putting an end to my life.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	10.52					
			11.42	88.58	5.41	-0.28	> .05
FLLRC	83	12.04					

Item 40 : I take tranquilizers.

Subjects	N	%	P	Q	°D%	CR	p
MLLRC	57	8.77					
			5.71	94.29	3.95	1.30	> .05
FLLRC	83	3.61					

Table 11 -Indicating differences between the percentages of Males Living in High Risk Conditions (MLHRC) and Males Living in Low Risk Conditions (MLLRC) on the following coping styles.

Item 1 : I often think that help would come from God.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	73.52					
			63.58	36.42	8.47	0.18	>.05
MLLRC	57	71.92					

Item 2 : I often think about the positive aspects of the situation.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	69.11					
			65.59	34.41	8.49	0.90	>.05
MLLRC	57	61.40					

Item 3 : I have found that only putting faith in God can change the circumstances.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	61.76					
			63.19	36.81	8.62	-0.36	>.05
MLLRC	57	64.91					

Item 4 : I learn new skills to tackle the problem more effectively.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	64.70					
			72.79	27.21	7.96	-2.22	>.05
MLLRC	57	82.45					

Item 5 : I try to figure out who is to be blamed for the situation.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	52.94					
			46.98	53.02	8.92	1.14	>.05
MLLRC	57	63.15					

Item 6 : I plan a strategy to deal with the problem effectively.

Subjects	N	%	P	Q	$^{c}D\%$	CR	p
MLHRC	68	57.35					
			58.39	41.61	8.81	-0.25	>.05
MLLRC	57	59.64					

Item 7 : I have been trying to cope with the situation through prayers and spiritual beliefs.

Subjects	N	%	P	Q	$^{c}D\%$	CR	p
MLHRC	68	50.00					
			46.39	53.61	8.92	0.88	>.05
MLLRC	57	42.10					

Item 8 : I engage in some creative activities like writing, reading, drawing etc.

Subjects	N	%	P	Q	$^{c}D\%$	CR	p
MLHRC	68	69.11					
			59.19	40.81	8.79	2.47	<.05
MLLRC	57	47.36					

Item 9 : I spend time alone and think about the situation.

Subjects	N	%	P	Q	$^{c}D\%$	CR	p
MLHRC	68	51.47					
			54.34	45.66	8.91	-0.72	>.05
MLLRC	57	57.89					

Item 10 : I discuss with other people and try to work out a plan to make the situation better.

Subjects	N	%	P	Q	$^{c}D\%$	CR	p
MLHRC	68	44.11					
			47.19	52.81	8.93	0.75	>.05
MLLRC	57	50.87					

Item 11 : I seek emotional support from others in solving the problem.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
MLHRC	68	42.64					
			36.68	63.32	8.62	-1.36	>.05
MLLRC	57	54.38					

Item 12 : I avoid the things that have caused the problem.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
MLHRC	68	41.17					
			43.19	56.81	8.86	-0.50	>.05
MLLRC	57	45.61					

Item 13 : I become irritable and blame the government and others for the situation.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
MLHRC	68	50.00					
			49.59	50.41	8.94	-0.09	>.05
MLLRC	57	49.12					

Item 14 : I have been trying to forget the trouble.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
MLHRC	68	48.52					
			47.19	52.81	8.93	0.35	>.05
MLLRC	57	45.61					

Item 15 : I engage in watching T.V.

Subjects	N	%	P	Q	$^{\sigma}D\%$	CR	p
MLHRC	68	27.94					
			39.99	60.01	8.76	-3.01	<.01
MLLRC	57	54.38					

Item 16 : I engage myself in seeking social support from family members.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	42.64					
			39.99	60.01	8.76	0.66	>.05
MLLRC	57	36.84					

Item 17 : I engage myself in meditation or relaxation exercise to overcome the problem.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	45.58					
			43.99	56.01	8.87	0.39	>.05
MLLRC	57	42.10					

Item 18 : I take some direct action to change the circumstances that have caused the problem.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	36.76					
			42.39	57.61	8.84	1.39	>.05
MLLRC	57	49.12					

Item 19 : I accept the situation as unavoidable.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	36.76					
			39.99	60.01	8.76	-0.80	>.05
MLLRC	57	43.85					

Item 20 : I go for a walk or short trips.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	58.82					
			54.39	45.61	8.90	1.08	>.05
MLLRC	57	49.12					

Item 21 : I take my mind away from the problem by engaging in humour talk.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	30.88					
			34.39	65.61	8.49	-0.90	>.05
MLLRC	57	38.59					

Item 22 : I engage myself in some other activities like dancing or listening to music.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	32.35					
			39.19	60.81	8.73	-1.71	>.05
MLLRC	57	47.36					

Item 23 : I prefer to sleep.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	29.41					
			29.59	70.41	8.16	-0.05	>.05
MLLRC	57	29.82					

Item 24 : I prefer to live alone and engage in self-talking.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	30.88					
			28.79	71.21	8.09	0.56	>.05
MLLRC	57	26.31					

Item 25 : I cut down my other responsibilities when the threatening situation arises.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	30.88					
			35.19	64.41	8.5	-1.11	>.05
MLLRC	57	40.35					

Item 26 : I drink more tea, Kahwa or coffee.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	23.52					
			27.99	72.01	8.03	-1.22	>.05
MLLRC	57	33.33					

Item 27 : I cry.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	17.64					
			15.99	84.01	6.55	0.55	>.05
MLLRC	57	14.03					

Item 28 : I feel like fighting.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	25.00					
			26.39	73.61	7.88	-0.38	>.05
MLLRC	57	28.07					

Item 29 : I divert my attention from discussion about the situation.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	26.47					
			23.19	76.81	7.54	0.95	>.05
MLLRC	57	19.29					

Item 30 : I put the problem out of my mind and refuse to think about it.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	22.05					
			20.79	79.21	7.25	0.38	>.05
MLLRC	57	19.29					

Item 31 : I withdraw from situations and make no attempt to cope with the problem.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	14.70					
			16.79	83.21	6.68	0.68	>.05
MLLRC	57	19.29					

Item 32 : I imitate the action of others who have had the same experience.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	35.29					
			30.39	69.61	8.22	1.30	>.05
MLLRC	57	24.56					

Item 33 : I blame myself and feel guilty about the situation which has happened.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	20.58					
			15.99	84.01	6.55	1.52	>.05
MLLRC	57	10.52					

Item 34 : I daydream and fantasize.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	17.64					
			21.59	78.41	7.36	-1.17	>.05
MLLRC	57	26.31					

Item 35 : I skip meals.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	14.70					
			13.59	86.41	6.13	0.39	>.05
MLLRC	57	12.28					

Item 36: I go to places where there are lots of people like clubs or marriage parties.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	13.2					
			16.77	83.23	6.67	-1.17	>.05
MLLRC	57	21.05					

Item 37 : I prefer not to make any attempt to deal with it.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	16.17					
			13.59	86.41	6.1	0.92	>.05
MLLRC	57	10.52					

Item 38 : I smoke cigarettes or tobacco.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	22.05					
			21.59	78.41	7.3	0.136	>.05
MLLRC	57	21.05					

Item 39 : I feel like putting an end to my life.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	16.17					
			13.59	86.41	6.130	0.92	>.05
MLLRC	57	10.52					

Item 40 : I take tranquilizers.

Subjects	N	%	P	Q	°D%	CR	p
MLHRC	68	5.88					
			7.19	92.81	4.62	-0.62	>.05
MLLRC	57	8.77					

Table 12 -Indicating differences between the percentages of Females Living in High Risk Conditions (FLHRC) and Females Living in Low Risk Conditions (FLLRC) on the following coping styles.

Item 1 : I often think that help would come from God.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	84.37					
			88.69	11.31	6.56	-0.91	>.05
FLLRC	83	90.36					

Item 2 : I often think about the positive aspects of the situation.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	71.87					
			75.64	24.36	8.90	-0.58	>.05
FLLRC	83	77.10					

Item 3 : I have found that only putting faith in God can change the circumstances.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	71.87					
			75.64	24.36	8.90	-0.58	>.05
FLLRC	83	77.10					

Item 4 : I learn new skills to tackle the problem more effectively.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	53.12					
			62.60	37.40	10.03	-1.31	>.05
FLLRC	83	66.26					

Item 5 : I try to figure out who is to be blamed for the situation.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	65.60					
			63.47	36.53	9.98	0.29	>.05
FLLRC	83	62.65					

Item 6 : I plan a strategy to deal with the problem effectively.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	62.50					
			64.34	35.66	9.93	-0.25	>.05
FLLRC	83	65.06					

Item 7 : I have been trying to cope with the situation through prayers and spiritual beliefs.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	59.37					
			68.68	31.32	9.61	-1.34	>.05
FLLRC	83	72.78					

Item 8 : I engage in some creative activities like writing, reading, drawing etc.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	59.37					
			59.12	40.88	10.19	0.33	>.05
FLLRC	83	59.03					

Item 9 : I spend time alone and think about the situation.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	62.50					
			46.95	53.05	10.34	0.01	>.05
FLLRC	83	62.65					

Item 10 : I discuss with other people and try to work out a plan to make the situation better.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	59.37					
			51.30	48.70	10.36	1.07	>.05
FLLRC	83	48.19					

Item 11 : I seek emotional support from others in solving the problem.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	53.12					
			48.68	51.32	10.36	0.59	>.05
FLLRC	83	46.98					

Item 12 : I avoid the things that have caused the problem.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	40.62					
			52.16	47.84	10.35	-1.54	>.05
FLLRC	83	56.62					

Item 13 : I become irritable and blame the government and others for the situation.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	53.12					
			46.08	53.92	10.33	0.94	>.05
FLLRC	83	43.37					

Item 14 : I have been trying to forget the trouble.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	46.87					
			50.42	49.58	10.36	-0.47	>.05
FLLRC	83	51.80					

tem 15 : I engage in watching T.V.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	43.75					
			53.03	46.97	10.34	1.24	>.05
FLLRC	83	56.62					

Item 16 : I engage myself in seeking social support from family members.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	32.00					
			49.19	50.44	10.36	0.47	>.05
FLLRC	83	48.19					

Item 17 : I engage myself in meditation or relaxation exercise to overcome the problem.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	46.87					
			45.21	54.79	10.32	0.22	>.05
FLLRC	83	44.57					

Item 18 : I take some direct action to change the circumstances that have caused the problem.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	34.37					
			42.62	57.38	10.25	-1.11	>.05
FLLRC	83	45.78					

Item 19 : I accept the situation as unavoidable.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	37.5					
			41.73	58.27	10.22	-0.57	>.05
FLLRC	83	43.37					

Item 20 : I go for a walk or short trips.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	37.50					
			31.30	68.70	9.61	0.89	>.05
FLLRC	83	28.91					

Item 21 : I take my mind away from the problem by engaging in humour talk.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	37.50					
			42.60	57.40	10.25	-0.68	>.05
FLLRC	83	44.57					

Item 22 : I engage myself in some other activities like dancing or listening to music.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	25.00					
			35.64	64.36	9.93	-1.48	>.05
FLLRC	83	39.75					

Item 23 : I prefer to sleep.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	37.5					
			39.12	60.88	10.12	-0.22	>.05
FLLRC	83	39.75					

Item 24 : I prefer to live alone and engage in self-talking.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	43.75					
			43.47	56.53	10.27	0.03	>.05
FLLRC	83	43.37					

Item 25 : I cut down my other responsibilities when the threatening situation arises.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	34.37					
			23.47	76.53	8.78	1.71	>.05
FLLRC	83	19.27					

Item 26 : I drink more tea, Kahwa or coffee.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	21.87					
			30.43	69.57	9.54	-1.24	>.05
FLLRC	83	33.73					

Item 27 : I cry.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	21.87					
			35.64	64.36	9.93	-1.92	>.05
FLLRC	83	40.96					

Item 28 : I feel like fighting.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	31.25					
			25.21	74.79	9.004	-0.92	>.05
FLLRC	83	22.89					

Item 29 : I divert my attention from discussion about the situation.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	25.00					
			27.82	72.18	9.29	-0.42	>.05
FLLRC	83	28.91					

Item 30 : I put the problem out of my mind and refuse to think about it.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	18.75					
			27.18	72.82	9.22	1.36	>.05
FLLRC	83	31.32					

Item 31 : I withdraw from situations and make no attempt to cope with the problem.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	15.62					
			11.29	88.71	6.56	-0.91	>.05
FLLRC	83	9.63					

Item 32 : I imitate the action of others who have had the same experience.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	15.67					
			14.77	85.23	7.35	0.15	>.05
FLLRC	83	14.45					

Item 33 : I blame myself and feel guilty about the situation which has happened.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	34.37					
			26.95	73.05	9.20	1.11	>.05
FLLRC	83	24.09					

Item 34 : I daydream and fantasize.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	18.75					
			21.73	78.27	8.55	0.48	>.05
FLLRC	83	22.89					

Item 35 : I skip meals.

Subjects	N	%	P	Q	σD%	CR	p
FLHRC	32	31.25					
			26.95	73.05	9.20	0.64	>.05
FLLRC	83	25.30					

Item 36: I go to places where there are lots of people like clubs or marriage parties.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	6.25					
			13.04	86.96	6.98	1.34	>.05
FLLRC	83	15.66					

Item 37 : I prefer not to make any attempt to deal with it.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	18.75					
			15.64	84.36	7.53	0.57	>.05
FLLRC	83	14.45					

Item 38 : I smoke cigarettes or tobacco.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	15.62					
			6.95	93.049	5.27	2.27	<.05
FLLRC	83	3.61					

Item 39 : I feel like putting an end to my life.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	15.62					
			13.036	86.964	6.98	0.51	>.05
FLLRC	83	12.04					

Item 40 : I take tranquilizers.

Subjects	N	%	P	Q	°D%	CR	p
FLHRC	32	15.62					
			6.95	93.04	5.27	2.27	<.05
FLLRC	83	3.61					

Traumatic Stress Significant differences were found between the percentages of Kashmiri people living in high and low risk conditions on certain traumatic stressors such as *threat of firing* (CR = 5.85, $p < .01$), *fear of crackdown and searching operations* (CR = 4.71, $p < .01$), *anger, hostility and aggressive behaviour of administration* (CR = 2.76, $p < .01$), *threat to life* (CR = 2.45, $p < .05$), *unexpected death of close family member during encounter* (CR = 2.44, $p < .05$), *disintegration/breaking of the family* (CR = 3.14, $p < .01$) and *sexual assault and rape* (CR = 27.46, $p < .01$). Significant differences were not found to exist between the Kashmiri people living in high and low risk conditions on the remaining items measuring traumatic stress.

There was no significance of difference between males and female subjects belonging to high risk conditions on traumatic stressors. That is, male and females perceived the similar amount of traumatic stress (cf. table 4). Significant difference existed between the comparison group only on *disintegration/breaking of the family* (CR = 4.06, $p < .01$).

Males living in low risk conditions have scored significantly higher percentages than the females living in low risk conditions on the following traumatic stressors : *anger, hostility and aggressive behaviour of administration, bomb blast near my house, threat of life, survived by chance, torture of a family member in the prison, detention in jail of a close family member, dissociation from family members and detention in jail of oneself.* On the remaining traumatic stressors, significant differences were not found to exist.

As regards to the within-group analysis, male subjects of high risk conditions and low-risk conditions differed significantly on on *bomb blast near my house* (CR = 2.66, p <.01) traumatic stress. Whereas on the remaining items representing the traumatic stress, male subjects of high and low risk conditions did not differ significantly.

Female subjects living in high risk conditions scored significantly higher than the female subjects living in low risk conditions on *anger, hostility and aggressive behaviour of administration, threat of life, unexpected death of a close family member during encounter, disintegration/breaking of the family and detention in jail of oneself* traumatic stressors.

The findings of the present study suggest that the main reason of traumatic stress in the case of Kashmiri individuals may be that there is the threat of significant resource loss. That is, stress occurs when there is actual resource loss. The present study is to compare people living in high and low risk conditions and gender-wise. A common set of traumatic tressors are perceived by the people within Kashmiri culture. For traumatic stressors in Kashmiri individuals, the occurrance of loss could have special meaning because traumatic losses are most clearly and closely linked to survival.

Coping Styles The present research has focussed on coping styles in order to cope with traumatic stress. In the present case coping styles has been defined as the ways people adopt in order to alleviate the potential negative effects of traumatic stress. Kashmiri people living in

low risk conditions tended to have their strongest beneficial effect from the following coping styles - *I engage in watching T.V.* and *I engage myself in some other activities like dancing, or listening to music.* People living in high risk conditions have been using the following coping styles to cope with traumatic stress : *I go for a walk or short trips* and *I smoke cigarettes or tobacco.* Interestingly, Kashmiri people living in high and low risk conditions have adopted both the functional and dysfunctional coping styles as the strategies to cope with their traumatic stressors.

Males as compared to females living in high risk conditions have expressed that they are functional styles like *I go for a walk or short trips* and *I imitate the action of others who have had the same experience* to cope with traumatic stress.

Females in comparison to males living in low risk conditions tend to express that they use following coping styles to overcome with traumatic stress : *I often think that help would come from God, I often think about the positive aspects of the situation, I have been trying to cope with the situation through prayers and spiritual beliefs, I prefer to live alone and engage in self-talking, I cry,* and *I blame myself and feel guilty about the situation that has happened.* The coping styles which the Kashmiri females use to cope with traumatic stress may be labelled as religious and dysfunctional or emotion focussed. Kashmiri males in comparison to females living in low risk conditions have reported that they use following styles - *I learn new skills to tackle the*

problem more effectively, I go for a walk or short trips, I cut down my other responsibilities upon the threatening situation arises and *I smoke cigarettes or tobacco to cope with traumatic stress.* These coping styles may be referred as functional and dysfunctional.

Male subjects living in low risk conditions have expressed that they tend to use significantly higher following coping styles : *I learn new skills to tackle the problem more effectively,* and *I engage in watching T.V.*; whereas males living in high risk conditions have tended to use *I engage in some creative activities like writing, reading, drawing etc.* By and large living conditions did not affect the coping styles. That is, irrespective of the living conditions, Kashmiri males use similar type of coping styles to cope with traumatic stress.

Significant differences were not found to exist between the females living in high risk conditions and the females living in low risk conditions on 38 coping styles (cf. Table 12). Females living in high risk conditions have scored significantly higher percentages than the females living in low risk conditions on *I smoke cigarettes or tobacco* and *I take tranquilizers coping styles.* In the case of Kashmiri females, living conditions did not affect the coping styles.

Chapter Five

CONCLUSIONS, IMPLICATIONS AND FUTURE DIRECTIONS

Conclusions

This section covers an integrative summary of the major findings found in the present study. The frequency of a broad range of traumatic stressors/experiences is an alarming fact in the population of Kashmir illustrated by the findings of the present study. The findings of the present study illustrate a clear connection between various traumatic events and high or low risk conditions. And on the basis of data analysis, the findings of the present study are as follows :

Kashmiri individuals living in low risk conditions scored significantly higher percentages on *threat of firing, fear of crackdown or searching operations,* and *sexual assault and rape* traumatic stressors, whereas Kashmiri individuals living in high risk conditions scored significantly higher percentages on *anger, hostility and aggressive behaviour of administration, threat to life, unexpected death of a close family member during encounter* and *disintegration / breaking of the family* traumatic stressors than the comparison groups.

Males living in low risk conditions have scored significantly higher percentages than the females living in low risk conditions on the following traumatic stress: *anger, hostility and aggressive behaviour of administration, bomb blast near to my house, threat to life,*

survived by chance, torture of a family member in the prison, detention in jail of a close family member, dissociation from the family members, and *detention in jail of oneself.*

Female subjects living in high risk conditions scored significantly higher than the female subjects living in low risk conditions on *anger, hostility and aggressive behaviour of administration, threat of life, unexpected death of a close family member during encounter, disintegration / breaking of the family,* and *detention in jail of oneself* traumatic stressors.

Kashmiri individuals living in high risk conditions have significantly adopted *I go for a walk or short trips,* and *I smoke cigarettes or tobacco* coping styles, whereas the Kashmiri individuals living in low risk conditions used significantly higher on *I engage in watching T.V.,* and *I engage myself in some other activities like dancing or listening to music* as the coping styles to cope with traumatic stressors.

Males living in high risk conditions as compared to females living in high risk conditions used significantly more the following coping styles: *I go for a walk or short trips* and *I imitate the action of others who have had the same experience.*

Significant differences were found to exist between the males living in low risk conditions and females living in low risk conditions on the following coping styles: *I often think that help would come from*

God, I often think about the positive aspects of the situation I learn new skills to tackle the problem more effectively, I have been trying to cope with the situation through prayers and spiritual beliefs, I go for a walk or short trips, I prefer to live alone and engage in self-talking, I cut down my other responsibilities when the threatening situation arises, I cry, I blame myself and feel guilty about the situation that has happened, and I smoke cigarettes or tobacco.

Significant differences were found to exist between males living in high risk conditions and males living in low risk conditions on *I learn new skills to tackle the problem more effectively* and *I engage in some creative activities like writing, reading, drawing etc.* coping styles.

Females living in high risk conditions scored significantly higher percentages than the females living in low risk conditions on *I smoke cigarettes or tobacco* and *I take tranquilizers* coping styles.

Implications

The present study has been conducted to explore traumatic stress and coping styles among people of Kashmir living in high and low risk conditions. Traumatic stressors and coping styles have been identified to know what type of traumatic stress the people of Kashmir perceived or experienced and what coping styles they used to cope with traumatic stress. The present research will help researchers to understand or to get an insight regarding the subfields of stress i.e. traumatic stress and coping behaviour. The research will provide the

basis for identifying the traumatic stress among people exposed to high risk and also help people to adopt healthy coping styles. Also, the research will provide a blue print of Kashmiri people's lifestyles. It also enables researchers to understand the behaviour of target population very clearly and also they will be able to know which type of coping style is required for the target population.

Future Directions

Research studies that have been cited in chapter two provide an excellent sampling of where the field of traumatic stress is at present. I am also intersted in where the field of traumatic stress will be, particularly in terms of (a) the impact of cultural and political factors on traumatic stress : (b) the prevalence and nature of traumatic events; (C) patterns of adjustment across time; (d) assessment techniques; and (e) intervention models and practices in the future.

(a) Cultural and Political Factors In most of the earlier studies, cultural and political factors involved in the field of traumatic stress are considered. In future studies it can be a struggle to examine the topic of trauma as a legitimate area of enquiry concerning war related trauma, torture victims, cultural attitude toward trauma victims. Terrorism-related trauma is viewed as an important contribution in facilitating a transition from a state of victimization (e.g., passiveness, hopelessness) to the state of survivorship (e.g., activeness, confidence).

(b) The Prevalence and Nature of Traumatic Events Various studies cited in chapter 2 relate well with the frequency of the following types

of traumatic events; war-related trauma, violent crime, natural and technological disasters, accidental injury, and torture. Norris (1992) reported that as many as one fifth of adults in the general population may experience a traumatic event each year. Freedy and Donkervoet (1995) reviewed a number of studies on the prevalence of traumatic events based on large general population surveys. Based on these surveys it was estimated that beteen 40% and 70% of adults have experienced at least one traumatic event during their lives. Until very recently the diagnostic nomenclature has under-estimated the frequency of traumatic events (APA, 1987, 1994). In future studies traumatic events should be considered in trying to ascertain factors that may play an important role in determining individual adjustment well-being.

Understanding the prevalence of terrorism-related trauma in societies or nations seem to be important in order to establish the relationship between trauma and mental health problems. It is very likely that a higher percentage of current mental health problems are environmentally induced than any other factor. If this assertion is correct, it implies that mental health professionals should focus more on preventing and managing the environmental causes of human suffering.

The quality of traumatic events is a crucial factor in determining the degree to which a traumatic event may have a negative mental health impact. Some combination of either objective (e.g., physical injury, death) or subjective (e.g., perception of threat to life,

perception of loss of control) dimensions of traumatic circumstances are believed to determine the risk for experiencing negative mental health outcomes. Clinical assessment should directly inquire about both the range of event types and the particular qualities of any events that have been experienced.

(c) Patterns of Adjustment Across Time From the earlier studies it appears that many victims of trauma may experience acute adjustment difficulties following traumatic events. Such studies are particularly informative with regard to the issue of patterns of post-trauma adjustment across the course of time. Another important issue concerns the timing of traumatic events with regard to development level. It is generally assumed that the early onset of traumatic experiences and/or repeated exposure to traumatic events delays or distorts normal psychosocial development. Important psychological resources such as trust, self-esteem, optimism, hope, well-being or sustained motivation to achieve goals may be damaged as the result of traumatic experiences. A fuller understanding of the potential impact of traumatic experiences is needed when the developmental range of the trauma victim is considered. Further studies should focus on trauma victims in order to facilitate the further development of positive psychological states and health (e.g., trust, self-esteem, optimism).

(d) Assessment Techniques The key issue which is involved with respect to the assessment of traumatic stressors/events is gathering and integrating appropriate sources of information concerning traumatic

stress. There is a need to develop standardized approach to assessment. Information can be gathered from a variety of sources such as personal interviews, record interviews, and psychological tests. The integration of these diverse sources of information can be helpful for the purposes of diagnosis and treatment planning. From this standpoint it is clear that the multidimensional assessment procedures are necessary to assess the particular types of trauma victims. Generally, a combination of interview and self-report techniques are recommended for this purpose. That is, the use of standardized procedures is recommended. Although the use of standardized assessment procedure that are specific to trauma population has advantages (e.g., brevity, standardization), some caution is warranted. Assessment should not be considered a simple task. Expert clinical judgement should be used in selecting, administering, scoring and interpreting assessment instruments. In future studies, attention should be paid to considering factors that might distort the accuracy of assessment findings (e.g., mental status, intellectual level).

(e) Intervention Models and Practices Clinical practice with trauma victims in Kashmir should occur within the context of an overall intervention plan. The intervention should consider both the level (i.e., individual versus systems level), the timings (i.e., prevention efforts that are primary, secondary, or tertiary in nature) of intervention efforts and the situations/areas (i.e., high and low risk). Psychotherapy and medications are the appropriate methods utilized by the interventionists in most clinical work. In the case of Kashmiri population, other

intervention possibilities include: community development (e.g., helping community members to build their own strengths or resources), or general education (e.g., crime prevention messages, prevention of traumatic events, shelter to terrorists), management of chronic symptomatology and rehabilitation counselling to manage intense affect and troubling thought processes, and to enhance internal resource (e.g., self-esteem) and external resources (e.g., social support).

As regards to the coping with traumatic stress, Kashmiri people living in high and low risk conditions should adopt a more satisfactory or healthy life style and should develop a broader social support system. These appear to be excellent and realistic coping styles for all traumatic stress victims.

REFERENCES

Abed, R.T. (1998). PTSD and victims of torture. *British Journal of Psychiatry*, 72 449.

Allen, J.R., Whittlesey, S., Pfefferbawn, B., & Ondersma, M.L. (1999). Community and coping of mothers and grandmothers of children killed in a human caused disaster. *Psychiatric Annals,* 29, 85-91.

Allen, S.F., Dlugkinski, E.L., Cohen, L.A., & Walker, J.L. (1999). Assessing the impact of a traumatic community event on children and assisting with their healing. *Psychiatric Annals,* 29, 93-98.

Almqvist, K., & Hwang, P. (1999). Iranian refugees in Sweden: Coping strategies processes in children and their families. *Childhood: A Global Journal of child Research,* 6, 167-188.

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed.) Washington, DC: Author.

American Psychiatric Association. (1987). Diagnostic and Statistical manual of mental disorders (3rd ed. rev.) Washington, DC: Author.

American Psychiatric Association (1994). Diagnostic and Statistical manual of mental disorders (4th ed. rev.) Washington, DC: Author.

Barlow, D.H. (1988). *Anxiety and its disorders: The nature and treatment of anxiety and panic.* New York: Guilfod Press.

Baum, A. (1987). Toxins, technology, and natural disasters. In G.R. Vanden Bos & B.K. Bryant (Eds.), *Cataclysms, crisis. and catastrophes: Psychology in action* (pp. 9-53) Washington DC: American Psychological Association.

Benington, C.C., Swift, E., Sanger, J., Smith, A. et al. (1999). Coping self-efficacy as a mediator of distress following a natural disaster. *Journal of Applied Social Psychology,* 29, 2443-2464.

Berkman, L.F., & Syme, S.L. (1979). Social networks, host resistance and mortality: a nine-year follow-up of Alameda County residents. *American Journal of Epidemiology,* 109, 186-204.

Billings, A.G., & Moos, R.H. (1984). Coping, Stress and social resources among adults with unipolar depression. *Journal of Personality and Social Psychology,* 46, 877-891.

Blanchard, E.B., Kolb, L.C., Gerardi, R.J., Ryan, P., & Pallmeyer, T.P. (1986). Cardiac response to relevant stimuli as a tool for diagnosing post-traumatic stress disorder in Vietnam veterans. *Behaviour Therapy,* 12, 592-606.

Blanchard, E.B., Kolb, L.C., Pallmeyer, T.P., & Gerardi, R.J. (1982) A psychophysiological study of post-traumatic stress disorder in Vietnam veterans. *Psychiatric Quarterly,* 54, 220-229.

Bolton, O., 'Ryan, D., Udwin, O., Boyle, S. et. al. (2000). The long term psychological effects of a disaster experienced in adolescence: II: General psychopathology. *Journal of Psychology and Psychiatry and Allied Disciplines,* 41, 513-523.

Breslau, N., Chilcoat, H.D., Kessler, R.C., & Davis, G.C. (1999). Previous exposure to trauma and PTSD effects of subsequent trauma. Results form Detroit Area survey of trauma. *American Journal of Psychiatry,* 156, 902-907.

Burkle, F.M. (1983). Coping with stress under condition of disaster and refugee care. *Military Medicine,* 148, 800-803.

Burke, R.J., & Wier, T. (1980). Coping with stress of managerial occupation. In C.L. Cooper & Payne (Eds.) *Current concerns in occupational stress,* (pp. 299-333). Chichester: Wiley.

Butcher, J.N., & Dunn, L.A. (1989). Human responses and treatment needs in airline disasters. In R. Gist & B. Lubin (Eds.), *Psychological aspects of disaster* (pp. 86-119). New York: John Wiley & Sons.

Butcher, J.N., & Hatcher, C. (1988). The neglected entity in air disaster planning: Psychological Services. *American Psychologist,* 43, 724-729.

Byrne, D. (1964). Repression-sensitization as a dimension of personality. In B.A. Maher (Ed.) *Progress in Experimental Personality Research* Vol. I. New York: Academic Press.

Carver, C.S., Scheir, M.F., & Weintraub, J.K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology,* 56, 267-283.

Chaffin, M., & Hanson, R.F. (2000). Treatment and multiply traumatized abused children. Treatment of child abuse: Common ground for mental health, medical, and legal practioners. R. Robert M. (Ed.) John Hopkins University Press: Baltimore, MD.

Chodoff, P. (1963). Late effects of the concentration camp syndrome. *Archives of General Psychiatry,* 8, 323-333.

Chung, M.C., Easthope, Y., Chung, C., & Clark-Cartier, D. (1999). The relationship between trauma and personality in victims of the Boeing 737-2DGC crash in Coventry. Journal of Clinical Psychology, 55, 617-629.

Cobb, S. (1976). 'Social support as a moderator of life stress'. *Psychosomatic Medicine,* 38, 300-314.

Cohen, F. (1987) Measurement of coping. In S.V. Kasal and C.L. Cooper (Eds.), *Stress and Health: Issues in Research Methodology.* New York: John Wiley.

Cohen, S., & Mckay. G. (1984). *Applied multiple regression/ correlation analysis for the behavioural sciences.* New York: Lawrence Erlbaum Associates.

Cohen, S., & Hoberman, H.M. (1983) Positive events and social supports as buffers of life change stress. *Journal of Applied Social Psychology,* 13, 99-125.

Chen, E., & Lazarus, R.S. (1973). Active coping processes, coping dispositions, and recovery from surgery. *Psychosomatic Medicine,* 35, 375-389.

Corneil, W,. Beaton, R., Murphy, S., Johnson, C. et. al. (1999). Exposure to traumatic incidents and prevalence of post-traumatic stress symptomatology in urban firefighters in two countries. *Journal of Occupational Health Psychology.* 4, 131-141.

Cunningham, M., & Cunningham, J.D. (1997). Patterns of symptomatology and patterns of torture. *Australian and New Zealand Journal of Psychiatry,* 31, 555-565.

Davis, C.G., Lehman, D.R., Wortman, C.B., Silver, R.C. et. al. (1995). The undoing of traumatic life events. *Personality Social Psychology Bulletin,* 21, 109-124.

Davis, C.G., Wortman, C.B., Lehman, D.R., & Silver, R.C. (2000). Searching for meaning in loss: Are clinical assumptions correct? *Death Studies,* 24, 497-540.

Dewe, P., Guest, D., & Williams, R. (1979). Methods of coping with work-related stress. In C. Mackey and T. Cox (Eds.). *Response to stress: Occupational aspects.* Guilford: IPC Science and Technology Press.

Dohrenwend, B.P., Raphel, K.G., Schwartz, S., Stueve, A., & Skodol, A. (1993). The structured event probe and narrative rating method for measuring stressful life events. In L. Goldberg. and S. Breznitz (Eds.). *Handbook of stress: Theoretical and Clinical aspects.* (pp. 174-199). New York: The Free Press.

Eisenbruch, M. (1991). From post-traumatic stress disorder to cultural bereavement: Diagnosis of southeast asian refugees. *Social Science Medicine,* 33, 673-680.

Elbedour, S. (1994). The psychological development of justice and injustice in child maltreatments: Some theoretical implications. *Early Child Development and Care,* 101, 23-32.

Endler, N.S., & Parker, J.D. (1990). Multidimensional assessment of coping: A critical evaluation. *Journal of Personality and Social Psychology,* 58, 844-854.

England, H. (1988). Death, trauma and ritual: Mozambican refugees in Malawi. *Social Science and Medicine,* 46, 1165-1174.

Erikson, E.H. (1959). The problem of ego identity. *Psychological* Issues, 1, 101-164.

Etinger, L. (1961). Concentration camp survivors in the post-war world. *American Journal of Orthopsychiatry,* 32, 367-375.

Favaro, A., Maiorani, M., Colombo, G., & Santonastaso, P. (1999). Traumatic experiences, posttraumatic stress disorder, and dissociative symptoms in a group of refugees from former Yugoslavia. *Journal of Nervous and Mental Disease.* 87, 306-308.

Fischman, Y. (1998). Metaclinical issues in the treatment of psychopolitical trauma. *American Journal of Orthopsychiatry,* 68, 27-38.

Foa, E.B., & Kozak, M.J. (1986). Emotional processing of fear: Exposure to corrective information, *Psychological Bulletin,* 99, 20-35.

Foa, E.B., Steketee, G., & Olasov-Rothbaum, B. (1989). Behavioural/ cognitive conceptualizations of posttraumatic stress disorder. *Behaviour Therapy,* 20, 155-176.

Folkman, S., & Lazarus, R.S. (1980). An analysis of coping in a middle aged community sample. *Journal of Health and Social Behaviour*, 21, 219-239.

Folkman, S., & Lazarus, R.S. (1985). If it changes it must be a process. A study of emotion and coping during three stages of a college examination. *Journal of Personality and Social Psychology,* 48, 150-170.

Folkman, S., Lazarus, R.S., Dunkel-Schetter, C., Delongis, A., & Gruen, J. (1986). The dynamics of a stressful encounter: Cognitive appraisal, coping and encounter outcomes. *Journal of Personality and Social Psychology,* 50, 992-1003.

Foy, D.W., Osato, S.S., Houskamp, B.M., & Neumann, D.A. (1993). Etiology of post-traumatic stress disorder. In P.A. Saigh (Ed.), *Posttraumatic stress disorder: A behavioural approach to assessment and treatment,* (pp. 28-49), New York: Pergamon Press.

Freedy, J.R. & Donkervoet, J.C. (1995). Traumatic Stress : An Overview of the Field. In J.R. Freedy and S.E. Hobfoll (Eds.). Traumatic Stress : From Theory to Practice. Chapter 1 (pp. 1-28) New York : Plenum Press.

Freedy, J.R., Kilpatrick, D.G. & Resnick, H.S. (1993). Natural disasters and mental health: Theory, assessment, and intervention. *Journal of Social Behaviour and Personality,* 8, 49-103.

Freedy, J.R., Saladin, M.E., Kilpatrick, D.C., Resnick, H.S., & Saunders, B.E. (1994). Understanding acute psychological distress following natural disasters. *Journal of Traumatic Stress,* 7, 257-273.

Freedy, J.R., Shaw, D.L., Jarrell, M.P. & Masters, C.R. (1992). Towards an understanding of the psychological impact of natural disasters: An application of the conservation resources stress model. *Journal of Traumatic Stress,* 5, 441-454.

Gershuny, B.S., & Thayer, J.F. (1999). Relations among psychological trauma, dissociative phenomena, and trauma-related distress: A review and integration. *Clinical Psychology Review.*

Gibbs, M.S. (1989). Factors in the victim that mediate between disaster and psychopathology: A review. *Journal of Traumatic Stress,* 2, 489-514.

Goldstein, M.J. (1973). Individual differences in response to stress. *American Journal of Community Psychology,* 2,113-137.

Gorst-Unsworth, C., & Goldenberg, E. (1998). Psychological sequelae of torture and organised violence suffered by refugees from Iraq: Trauma-related factors compared with social factors in exile. *British Journal of Psychiatry,* 172, 90-94.

Grame, C.J., Jortorici, J.S., Healey, B.J., Dillingham, J.H. et. al. (1999). Addressing spiritual and religious issues of clients with a history of psychological trauma. *Bulletin of the Menninger Clinic,* 63, 223-239.

Green, B.C., & Gleser, G.C. (1983). Stress and long term psychopathology in survivors of the Buffalo Creek disaster. In D. Ricks and B.S. Dohrenwend (Eds.) *Origins of psychopathology* (pp. 73-90). New York: Cambridge University Press.

Green, B.L., Grace, M.C., & Gleser, G.C. (1985). Identifying survivors at risk : Long term impairment following the Beverly Hills Supper Club fire. *Journal of Consulting and Clinical Psychology,* 53, 672-678.

Green, B.L., Lindy J.D., Grace, M.C., Gleser, G.C., Leonard, A.C., Karol, M., & Winget, C. (1990). Buffalo Creek survivors in the second decade: Stability of stress symptoms. *American Journal of Orthopsychiatry,* 60, 43-54.

Gurwitch, R.M., Sullivan, M.A., & Long P.J. (1998). The impact of trauma and disaster on young children. *Child and Adolescent Psychiatric Clinics of North America,* 7, 19-32.

Hann, N. (1977). *Coping and defending.* New York: Academic Press.

Harvey, A.G., & Bryant, R.A. (1999). Acute stress disorder across trauma populations. *Journal of Nervous and Mental Disease,* 187, 443-446.

Harvey, J.H., Stein, S.K., Olsen N., & Richards, J. (1995). Narratives of loss and recovery from a natural disaster. *Journal of social Behaviour and Personality,* 10, 313-330.

Hodgkinson, P.E., & Shepard, M.A. (1994). The impact of disaster support work. *Journal of Traumatic Stress.* 7, 587-600.

Hobfoll, S.E. (1988). *The ecology of stress.* Washington, DC: Hemisphere Publishing.

Hobfoll, S.E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist.* 44, 513-524.

Hobfoll, S.E. (1991). Traumatic stress: A theory based on rapid loss of resources. *Anxiety Research,* 4, 187-197.

Hobfoll, S.E., Dunahoo, C.L., Ben-Porath, Y., & Monnier, J. (1994). Gender and coping: The dual axis model of coping. *American Journal of Community Psychology,* 22, 49-82.

Hobfoll, S.E., Dunahoo, C.A. & Monnier, J. (1995). Conservation of resources and traumatic Stress. In J.R. Freedy and S.E. Hobfoll (Eds.) *Traumatic Stress: From Theory to Practice.* Chapter 2, (pp. 29-47), New York : Plenum.

Hobfoll, S.E., & Jackson, A.P. (1991). Conservation of resources in community intervention. *American Journal of Community Psychology,* 19, 111-121.

Hobfoll, S.E., & Learman, M.(1988). Personal relationships, personal attributes and stress resistance: Mothers' reactions to their child's illness. *American Journal of Community Psychology,* 16, 565-589.

Hobfoll, S.E., & Learman, M. (1989). Predicting receipt of social support: A longitudinal study of parents' reactions to their child's illness. *Health Psychology,* 8, 61-77.

Hobfoll, S.E., & Lily, R.S. (1993). Resource conservation as a strategy for community psychology. *Journal of Community Psychology,* 21, 128-148.

Hobfoll, S.E., & London, P. (1986). The relationship of self-concept and social support to emotional distress among women during war. *Journal of Social and Clinical Psychology,* 12, 87-100.

Hobfoll, S.E. London, P., & Orr, E. (1988). Mastery, intimacy, and stress resistance during war. *Journal of Community Psychology,* 16, 317-331.

Hobfoll, S.E., Lomranz, J., Eyal, N., Bridges, A., & Tzemach, M. (1989). Pulse of a nation: Depressive mood reactions of Israelis to the Israel-Lebanon War. *Journal of Personality and Social psychology,* 56, 1002-1012.

Hobfoll, S.E., Nadler, A., & Leiberman, J. (1986). Satisfaction with social support during crisis: Intimacy and self-esteem as critical determinants. *Journal of Personality and Social Psychology,* 51, 296-304.

Holahan, C.J., Moos, R.M., & Schaefer, J.A. (1996). Coping, stress resistance, and growth: Conceptualizing adaptive functioning. In M. Zeidner and N.S. Endler (Eds.) *Handbook of Coping: Theory, research, applications* (pp. 24-43) New york: John Wiley & Sons.

Holahan, C.J., & Moos, R.H. (1986). 'Personality, coping and family resources in stress resistance : a longitudinal analysis'. *Journal of Personality and Social Psychology*, 57: 385-95.

Holmes, T.H., & Raye, R.H. (1967). The social readjustment rating scale. *Journal of Pschosomatic Research,* 11, 213-218.

Horowitz, M.J. (1986). *Stress response syndromes* (2nd ed.) Northvale, NJ: Jason Aronson.

Houstan, K. (1986). Stress and Coping.

Husain, S.A., Nair, J., Holcomb, W., Reid, J.C. et. al. (1998). Stress reactions of children and adolescents in war and seige conditions. *American Journal of Psychiatry,* 155, 1718-1719.

Jacobs, G.A., Quevillon, R.P., & Stricherz, M. (1990). Lessons from the aftermath of Flight 232: Practical considerations for the mental health profession's response to air disasters. *American Psychologist,* 45, 1329-1135.

Janis, I.L., & Mann, L. (1976) Coping with decisional conflict. *American Scientist,* 64, 657,667.

Janoff, B., Ronnie. & Berger, A.R. (2000). The other side of trauma: Towards of psychology of appreciation. In J.H. Harvey., and E.D. Miller (Eds.)., *Loss and Trauma:General and close relationship perspectives.* Philadelphia, PA. Bruner-Routledge.

Jones, J.C., & Barlow, D.H. (1990). The etiology of posttraumatic stress disorder. *Clinical Psychology Review,* 10, 299-328.

Kahn, R.L., Wolfe, D.M., Quinn, R.P., Snoek. J.D., & Rosenthal, R.A. (1964). *Organisational Stress Studies role conflict and ambiguty.* New York: Wiley.

Kaniasty, K., & Norris, F.H. (1993). A test of the social support deterioration model in the context of natural disaster. *Journal of personality and Social Psychology,* 64, 395-408.

Katz, J., Weiner H., Gallagher, T., & Hellman. L. (1970) Stress, distress and ego defenses. *Archives of General Psychiatry,* 23, 131-142.

Keane, T.M., Zimering, R.T., & Caddell. J.M. (1985). A behavioural formulation of post-traumatic stress disorder in Vietnam veterans. *The Behaviour Therapist,* 8, 9-12.

Kilborne, B. (1998). When trauma strikes the soul. Shame splitting psychic pain. *American Journal of Psychoanalysis,* 58, 385-402.

Kilpatrick, D.G., Best, C.L., Veronen, L.J., Amick, A.E., Villeponteaux, L.A., & Ruff, G.A. (1985). Mental health correlates of criminal victimization: A random community survey. *Journal of Consulting and Clinical Psychology,* 53, 866-873.

Kilpatrick, D.G., & Resnick, H.S. (1993). Post-traumatic stress disorder associated with exposure to criminal victimization in clinical and community populations. In J.R.T. Davidson and E.B. Foa (Eds.) *Post traumatic stress disorder : A review in recent research and future directions* (pp. 113-146). Washington, DC: American Psychiatric Press.

Kilpatrick, D.G., Veronen L.J., & Resick, P.A. (1979). Assessment of the aftermath of rape: Changing patterns of fear. *Journal of Behaviour Assessment,* 1, 133-148.

King, A., & Miner, K.N. (2000). Writing about the perceived benefits of traumatic events : Implications for physical health. *Personality and Social Psychology Bulletin.* 26, 220-230.

Kinzie, J.D. (1989). Therapeutic approaches to traumatized Cambodian refugees. *Journal of Traumatic Stress,* 2, 75-91.

Kinzie, J.D., Sach, W.H., Angell, R.H., Clark, G., & Ben, R. (1989). A three year follow-up of Cambodian young people traumatized as children. *Journal of the American Academy of Child and Adolescent Psychiatry,* 28, 501-504.

Kiser, L.J., Ostaja, E., & Pruitt, D.B. (1998). Dealing with stress and trauma in families. *Child and Adolescent Psychiatric Clinics of North America,* 7, 87-103.

Klingman, A. (1994). Children response to the Gulf war. Assessment via ordinal and nominal quantification of compositions. *School Psychology International,* 13, 235-246.

Kolb, L.C. (1988). A critical survey of hypotheses regarding PTSD in light of recent research findings. *Journal of Traumatic Stress,* 1, 291-304.

Kubany, E.S., Aburg, F.R., Kilauano, W.L., Frederic, P. et al. (1997). Development and validation of the sources of Trauma-Related Guilt Survey-War Zone Version. *Journal of Traumatic Stress,* 10, 235-258.

Kuch, K., Swinson, R.P., & Kirby, M. (1985). Post-traumatic stress disorder after car accidents. *Canadian Journal of Psychiatry,* 30, 426-427.

Lazarus, R.S. (1974). The psychology of coping: Issues of Research and Assessment. In G.V. Geolha, D.A. Hamburg, and J.E. Adams (Eds.) *Coping and adaptation.* New York: Basic Books.

Lazarus, R.S. (1975). The self-regulation of emotion. In L. Levi (Ed.). *Emotions: Their parameter and measurement.* New York: Raven Press.

Lazarus, R.S. (1981). The stress and coping paradigm. In C. Eisdorfer, D. Cohen, A. Kleinman, and P. Maxim (Eds.). *Modes of clinical psychology.* New York: Spectrum.

Lazarus, R.S., & Folkman, S. (1984). *Stress appriasal and coping.* New York: Springer.

Lazarus, R.S., & Launier, P. (1978). Stress related transactions between person and environment. In L.A. Pervin and M. Lewis (Eds.). *Perspectives in Interactional Psychology.* New York: Plenum.

Lingma, A., & Kupermint, H. (1994). Response style and self-contol under scud missile attacks: The case of the sealed room situation during the 1991 Gulf War. *Journal of Traumatic Stress.* 7, 415-428.

Liabre, M.M., & Hadi, F. (1997). Social support and psychological distress in Kuwaiti boys and girls exposed to the Gulf crisis. *Journal of Clinical Child Psychology,* 26, 247-255.

Lomranz, J., Hobfoll, S.E., Johnson, R., Eyal, N., & Zemach, M. (1994). A nations response to attack: Israelis' depressive reactions to the Gulf war. *Journal of Traumatic Stress,* 7, 55-69.

Maddi, S.R., & Kobasa, D.M. (1984). Hardiness and mental health. *Journal of Personality Assessment,* 63, 265-274.

Martinez-Taboas, A., & Bernav, G. (2000). Dissociation Psychopathology, and abusive experiences in a nonclinical Lation University Student group. *Cultural Diversity and Ethnic Minority Psychology.* 6, 32-42.

McCann, L., & Pearlman, L.A. (1990). *Psychological trauma and the adult survivor: Theory, therapy and transformation.* New York: Bruner / Mazel.

McCann, I.L., Sakheim, D.K., & Abrahamson, D.J. (1988). Trauma and victimization: A model of psychological adaptation. *The Counselling Psychologist.* 16, 531-594.

McFarlane, A.H. (1992). Avoidance and intrusion in post-traumatic stress disorder. *Journal of Nervous and Mental Disease.* 180, 439-445.

McGrath, J.E. (1976). Stress and behaviour in organization. In M. Dunnette (Ed.). *Handbook of Industrial and organisational Psychology,* Chicago: Random Macnally.

Mechanic, D. (1974). Social structure and personality adaptation: Some neglected dimensions: In G.V. Coelho, O.A. Hamdurg, and J.E. Adams. (Eds.) *Coping and adaptation.* New York: Basic Books.

Meichenbaum, D.H. (1977). *Cognitive behaviour modification.* New York: Plenum.

Menninger, K. (1963). The vital balance : The life process in mental health and illness. New York : Viking.

Meszen-Niejodek, I. (1997). Coping style and its role in coping with stressful encounters. *European Psychologists,* 2, 242-351.

Miliora, M.T. (2000). Beyond empathic failures: Cultural racism as narcissistic trauma and disenfranchisement of grandiosity. *Clinical Social Work Journal,* 28, 43-54.

Miller, S.M. (1985). Monitors vs blunters: Validation of a questionnaire to assess two styles of information seeking under threat. In A. Steptoe., and J.O. Sullivan (1986) Monitoring and blunting coping styles in women prior to surgery. *British Journal of Clinical Psychology,* 25, 143-144.

Million. T., Green, C.J., & Meagher, R.B. (1982). *Million Behavioural Health Inventory Manual.* 3rd Edition, Interpretative Scoring System, Minnesota.

Monet, R., & Lazarus, R.S. (1977). *Stress and coping. An anthology.* New York: Columbia University Press.

Murray, E.S., & Daniel, L. (1994). Emotional processing in vocal and written expression of feelings about traumatic experiences. *Journal of Traumatic Stress.* 7, 391-405.

Mowrer, O.H. (1960). *Learning theory and behaviour.* New York: John Wiley & Sons.

Nicholas, M., & Forrester, A. (1999). Advantages of heterogenous therapy groups in the psychotherapy of the traumatically abused. Treating the problem as well as the person. *International Journal of Group Psychotherapy,* 49, 323-342.

Norris, F. (1990). Screening for traumatic stress: A scale for use in the general population. *Journal of Applied Social Psychology,* 20, 1704-1718.

Norris, F.H. (1992). Epidemiology of trauma : Frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consulting and Clinical Psychology*, 60, 409-418.

Nowack, K.M. (1990). Initial development of an inventory to assess stress and health risk. *American Journal of Health Promotion,* 4, 173-180.

Ozer, E.M., & Bandura, A. (1990). Mechanisms governing empowerment effects: A self-efficacy analysis. *Journal of Personality and Social Psychology,* 58, 472-486.

Pallmeyer, T.P., Blanchard, E.B., & Kolb, L.C. (1986). The psychophysiology of combat-induced post-traumatic stress disorder in Vietnam veterans. *Behaviour Research and Therapy,* 24, 645-652.

Pareek, U. (1983). *Organizatonal Role PICS Manual.* Indian Institute of Management, Ahmedabad.

Parker, G. (1997). Cyclone Tracy and Darwin evacuees: On the restoration of the species. *British Journal of Psychiatry,* 130, 548-555.

Pinkerton, P., Trauer, T., Duncan, F., Hodson, M.E., & Batteon J.C. (1985). Cystic Fibrosis in adult life: a study of coping patterns. *The Lancet,* 2, 761-763.

Pitman, R.K., Orr, S.P. Forgue, D.F. Altman, B., deJong, J.B., & Hertz, L.R. (1990). Psychophysiologic responses to combat imagery of Vietnam veterans with Posttraumatic Stress Disorder versus other anxiety disorders. *Journal of Abnormal Psychology,* 99, 49-54.

Prigerson, H.G., Shear, M.K., Jacobs, S.C., Reynolds, C.F. III et. al. (1999). Consensus criteria for traumatic grief: A preliminary empirical test. *British Journal of* Psychiatry, 174, 67-73.

Punamaki, R.L. (1999). The relationship of dream content and changes in daytime mood in traumatized vs non-traumatized children *Dreaming: Journal of the Association for the study of Dreams,* 9, 213-233.

Resick, P.A., & Schnicke, M.K. (1993). *Cognitive processing therapy for sexual assualt victims: A treatment Manual.* Newbury Park. CA: Sage.

Roemer, L. Orsillo, S.M., Borkovec, T.D., & Litz Brett T. (1998). Emotional response at the time of a potentially traumatizing event and PTSD symptomatology: A preliminary retrospective analysis of the DSM-IV criteria A-2. *Journal of Behaviour Therapy and Experimental Psychiatry,* 29, 123-130.

Roth, S., & Cohen, L.J. (1986). Approach, avoidance and coping with stress. *American Psychologist,* 41, 813-819.

Rubonis, A.V., & Bickman, L. (1991). Psychological impairment in the wake of disaster: The disaster-psychopathology relationship. *Psychological Bulletin,* 109, 384-399.

Ruch, L.O., & Leon, J.J. (1986). The victim of rape and the role of life change, coping and social support during the rape trauma syndrome. In S.E. Hobfoll (Ed.) *Stress, social support, and women* (pp. 137-152). Washington, DC: Hemisphere Publishing.

Sadavoy, J. (1997). A review of the late-life effects of prior psychological trauma. *American Journal of Geriartic Psychiatry,* 5, 287-301.

Schonpflug, W. (1985). Goal directed behaviour as a source of stress: Psychological origins and consequences of inefficiency. In M. Frese and J. Sabini (Eds.) *Goal directed behaviour: The concept of action in psychology* (pp. 172-188). Hillsdale, NJ: Lawrence Erlbaum.

Schwatz, S.H., & Bilsky, W. (1990). Toward a theory of the Universal content and structure of values: Extensions and cross-cultural replications. *Journal of Personality and Social Psychology,* 58, 878-891.

Schweidson, E. (1998). The silence from a pertified past. *International Forum of Psychoanalysis,* 7, 113-119.

Scotti, J.R., Beach, B.K., Northrop, L.M.E., Rode, C.A., & Forsyth, J.P. (1995). The psychological impact of accidental injury. In J.R. Freedy and S.E. Hobfoll (Eds.) *Traumatic Stress: From Theory to Practice,* (pp. 181-212), New York : Plenum Press.

Selye, H. (1956). *The Stress of Life.* New York: McGraw-Hill Book Company.

Selye, H. (1976). *The Stress of Life* (Rev. ed.) New York: McGraw Hill Book Company.

Seligman, Z. (1995). Trauma and drama: A lesson from the concentration camps. *Arts in psychotherapy,* 22,119-132.

Shaw, J.A. (2000). Children, adolescents and trauma. *Psychiatric Quarterly,* 71, 227-243.

Silove, D. (1999). The psychological effects of torture, mass human rights violations, and refugee trauma. Toward an integrated conceptual framework. *Journal of Nervous and Mental Disease,* 187, 200-207.

Solomon, Z. (1988). The effects of combat-related posttraumatic stress disorder on the family. *Psychiatry,* 51, 323-329.

Solomon, Z., Ginzberg, K., Mikulinear, M., Neria, Y. et al. (1998). Coping with war captivity: The role of attachment style. *European Journal of Personality,* 12, 271-285.

Solomon, E.P., & Heide, K.M. (1999). Type III trauma: Toward a more effective conceptualization of psychological trauma. *International Journal of Offender Therapy and Criminology.* 43, 202-210.

Stone, A.A., Greenberg, M.A., Kenedy-Moore, E., & Newman, M.G. (1991). Self-report, situation specific coping questionnaires: What are they measuring? *Journal of Personality and Social Psychology,* 61, 648-658.

Straker, G., & Moosa, F. (1994). Interacting with trauma survivors in context of continuing trauma. *Journal of Traumatic Stress.* 73, 457-465.

Thoits, P.A. (1983). Dimensions of life events that influence psychological distress: An evaluation and synthesis of the literature. In H.B. Kaplan (Ed.)., *Psychological stress: Trends in theory and research* (pp. 33-103). New York: Academic Press.

Tversky, A., & Kahneman, D. (1981). The framing of decisions and the psychology of choice. *Science,* 24, 453-458.

Tymstra, T. (1989). The imperative character of medical techology and the meaning of "anticipated decision regret". *International Journal of Technology Assessment in Health Care,* 5, 207-213.

Ullman, S.E., & Siegal, J.M. (1994). Predictors of exposure traumatic events and post-traumatic stress sequelae. *Journal of Community Psychology,* 22, 328-338.

Vaillant, G.E. (1977). *Adaptation to life.* Boston: Little Brown.

van der Kolk, B., Greenberg, M., Boyd, H., & Krystal, J. (1985). Inescapable shock, neurotransmitters, and addiction to trauma: Toward a psychobiology of posttraumatic stress. *Biological Psychiatry,* 20, 314-325.

Vesti, P., & Kastrup, M. (1992). Psychotherapy for torture survivors. In M. Basoglu (Ed.) *Torture and its consequences: Current treatment approaches* (pp. 348-362). Cambridge: Cambridge University Press.

Viney, L., & Westbrook. M.T. (1982). Coping with chronic illness: The mediating role of biographic and illness related factors. *Journal of Psychosomatic Research,* 26, 595-605.

White, R. (1974). Strategies of adaptation: An attempt at systematic description. In G.V. Coelho, D.A. Hamburg., and J.E. Adams (Eds.). *Coping and adaptation.* New York: Basic Books.

Wilder, J.F., & Plutchick. R. (1982). Preparing the professional: Building prevention into training. In W.S. Pine (Ed.)., *Job stress and burnout: Research. theory and intervention perspectives.* Beverly Hills. Sage publications.

Williams, C.L., Solomon, S.D., & Bartone, P. (1988). Primary prevention in aircraft disasters: Integration research and practice. *American Psychologist,* 43, 730-739.

Wilson, J.P., & Moran, T.A. (1998). Psychological trauma: Posttraumatic stress disorder and spirituality. *Journal of Psychology and Theology,*26, 168-178.

Wolf,. S., & Goodell, M. (1968). In M.G. Wolff's *Stress and disease.* Springfield, III: Charles C. Thomas Publications.

Wortman, C.B., & Dunkel-Schetter, C. (1979). Interpersonal relationships and cancer: A theoretical analysis. *Journal of Social Issues.* 35, 120-155.

Wozniak, J., Crawford, M.H., Biederman, J., Faraone, S.V. et al. (1999). Antecedents and complications of trauma in boys with ADHD. Findings from a logitudinal study. *Journal of the American Academy of Child and Adolescent Psychology,* 38, 48-56.

Wyshak, G. (1994). The relation between change in reports of traumatic events and symptoms of psychiatric distress. *General Hospital Psychiatry,* 16, 290-297.

Yehuda, R., McFarlane, A.C., & Shalev, A.Y. (1998). Predicting the development of posttraumatic stress disorder form the acute response to a traumatic event. *Biological Psychiatry,* 44, 1305-1313.

Yeh, C., & Wang, Y.W. (2000). Asian American coping attitudes, sources, and practices: Implications for indigenous counselling strategies. *Journal of College Student Development,* 4, 94-103.

Zafrir, A. (1982). Community therapeutic intervention in treatment of civilian victims after a major terrorist attack. In C.D. Spielberger and I.G. Sarason (Eds.) & N.A. Milgram (Guest Ed.), *Stress and Anxiety:* Vol 8 (pp. 303-315). New York: Hemisphere Publishing.

APPENDICES

TRAUMATIC STRESS INVENTORY

Direction This is a simple questionnaire containing thirty items pertaining to the traumatic experiences. There is no right or wrong answer. The items which are applicable to your past state of condition or experience are to be marked 'Yes' by putting a tick mark in a bracket ( ) against it under the column 'Yes'. If the item is not applicable to you, put a tick mark under the column 'No'. Read all the items carefully and give your responses candidly.

		Yes	No
1.	Threat of firing.	( )	( )
2.	Fear of crackdown or searching operations.	( )	( )
3.	Panic.	( )	( )
4.	Threat of war/violence.	( )	( )
5.	Anger, hostility and aggressive behaviour of administration	( )	( )
6.	Bomb blast near my house.	( )	( )
7.	Death of a close family member.	( )	( )
8.	Threat of life.	( )	( )
9.	Survived by chance.	( )	( )
10.	Survival by freak circumstances.	( )	( )
11.	Financial losses	( )	( )
12.	Tension caused by resistance and ignoring the warning to cooperate/to obey.	( )	( )
13.	Migration to safer places and displacement.	( )	( )
14.	Troublesome neighbours.	( )	( )
15.	Major personal illness or injury.	( )	( )
16.	Self or family members become unemployed.	( )	( )
17.	Enforced change of residence.	( )	( )
18.	Robbery or theft in the house.	( )	( )

19. Torture of a family member in the prison.	( )	( )
20. Seeing death of military jawans.	( )	( )
21. Separation reactions of young children.	( )	( )
22. Detention in jail of a close family member.	( )	( )
23. Unexpected death of a close family member during encounter.	( )	( )
24. Disintegration/breaking of the family.	( )	( )
25. Dissociation from the family member.	( )	( )
26. Robbery of expensive valuables during search operations.	( )	( )
27. Demands after abduction of a family member.	( )	( )
28. Abduction	( )	( )
29. Detention in jail of oneself.	( )	( )
30. Sexual assault and rape.	( )	( )

COPING STYLES INVENTORY

Directions Read each statement carefully and tick only those items which indicate what you have been doing to cope with traumatic stress. Obviously people deal with traumatic stress or situations in different ways, but I am interested in knowing how you have tried to deal with it.

1. I often think that help would come from God.
2. I often think about the positive aspects of the situation.
3. I have found that only putting faith in God can change the circumstances.
4. I learn new skills to tackle the problem more effectively.
5. I try to figure out who is to be blamed for the situation.
6. I plan a strategy to deal with the problem effectively.
7. I have been trying to cope with the situation through prayers and spiritual beliefs.
8. I engage in some creative activities like writing, reading, drawing etc.
9. I spend time alone and think about the situation.
10. I discuss with other people and try to work out a plan to make the situation better.
11. I seek emotional support from others in solving the problem.
12. I avoid the things that have caused the problem.
13. I become irritable and blame the government and others for the situation.
14. I have been trying to forget the trouble.
15. I engage in watching T.V.
16. I engage myself in seeking social support from family members.
17. I engage myself in meditation or relaxation.
18. I take some direct action to change the circumstances that have caused the problem.
19. I accept the situation as unavoidable.

20. I go for a walk or short trips.
21. I take my mind away from the problem by engaging in humour talk.
22. I engage myself in some other activities like dancing or listening to music.
23. I prefer to sleep.
24. I prefer to live alone and engage in self-talking.
25. I cut down my other responsibilities when the threatening situation arises.
26. I drink more tea, kahwa or coffee.
27. I cry.
28. I feel like fighting.
29. I divert my attention from discussion about the situation.
30. I put the problem out of my mind and refuse to think about it.
31. I withdraw from situations and make no attempt to cope with the problem.
32. I imitate the action of others who have had the same experience.
33. I blame myself and feel guilty about the situation that has happened.
34. I day dream and fantasize.
35. I skip meals.
36. I go to places where there are lots of people like clubs or marriage parties.
37. I prefer not to make any attempt to deal with it.
38. I smoke cigarettes or tobacco.
39. I feel like putting an end to my life.
40. I take tranquilizers.